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ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAM

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ZISSP
Increasing the use of High Impact Health Services

The Zambia Integrated Systems Strengthening Program is a technical assistance program to support the Government of Zambia. The Zambia Integrated Systems Strengthening Program is managed by Abt Associates Inc. in collaboration with Akros Research Inc., American College of Nurse-Midwives, Banyan Global, and John Hopkins Bloomberg School of Public Health-Center for Communication Programs, Liverpool School of Tropical Medicine, and Planned Parenthood Association of Zambia. The project is funded by the United States Agency for International Development (USAID), under contract GHH-I-00-07-00003 (Order No. GHS-I-11-07-00003-00)

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Acronyms

ACNM	American College of Nurse Midwives
ACT	Artemisinin-Combination Therapies
ADH	Adolescent Reproductive Health
AIDS	Acquired Immunodeficiency Syndrome
AIRS	Africa Indoor Residual Spraying
APAS	Annual Performance Appraisal System
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
BFHFI	Baby Friendly Health Facility Initiative
BRITE	BroadReach Institute for Training and Education
CBD	Community-based Distributor
CBGMP	Community-Based Growth Monitoring and Promotion
CCP	Center for Communications Programs
CCS	Clinical Care Specialists
CCT	Clinical Care Team
CHC	Community Health Coordinators
CHV	Community Health Volunteers
CHW	Community Health Workers
CSH	Communications Support for Health
DCCT	District Clinical Care Team
DCMO	District Community Medical Office
DDMS	Disease Data Management Systems
DEM	Direct Entry Midwifery
DHMT	District Health Management Team
DHO	District Health Office/er
DHRA	Director of Human Resources and Administration
DQA	Data Quality Audit
EHT	Environmental Health Technician
EmONC	Emergency Obstetric and Newborn Care
FANC	Focused Antenatal Care
FP	Family Planning
GIS	Geographic Information Systems
GNC	General Nutrition Council
HBLSS	Home Based Life Serving Skills
HIV	Human Immunodeficiency Virus
HMIS	Health Management and Information System
HPCZ	Health Professions Council of Zambia
HR	Human Resources
HRIS	Human Resources Information System
HRH	Human Resources for Health
ICATT	IMCI Computerized Adaptation and Training Tool
iCCM	Integrated Community Case Management
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness

IRS	Indoor Residual Spraying
IT	Information Technology
IPTp	Intermittent Preventive Therapy
IYCF	Infant and Young Child Feeding
LAFP	Long Acting Family Planning
M&E	Monitoring and Evaluation
MAIYCN	Maternal, Adolescent and Infant and Young Child Nutrition
MCDMCH	Ministry of Community Development, Mother and Child Health
MOH	Ministry of Health
MS	Management Specialist
MTEF	Mid-Term Evaluation Framework
NFNC	National Food and Nutrition Commission
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHC	Neighborhood Health Committee
NIPA	National Institute for Public Administration
NMCC	National Malaria Control Centre
NMCP	National Malaria Control Program
NMSP	National Malaria Strategic Plan
ORT	Oral Rehydration Therapy
PA	Performance Assessment
PDA	Personal Digital Assistant
PEPFAR	President's Emergency Plan for AIDS Relief
PHO	Provincial Health Office
PMEP	Performance Monitoring and Evaluation Plan
PMI	President's Malaria Initiative
PMO	Provincial Medical Office
PMP	Performance Management Package
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPAZ	Planned Parenthood Association of Zambia
PPE	Personal Protective Equipment
PPH	Post-partum hemorrhage
PSMD	Public Service Management Division
QI	Quality Improvement
RDL	Radio Distance Learning
RDT	Rapid Diagnosis Testing
RED	Reach Every District
SHA	System of Health Accounts
SMAG	Safe Motherhood Action Group
SMGL	Saving Mothers Giving Lives
SOP	Standard Operating Procedures
TOT	Training of Trainers
TSS	Technical Support Supervision
TWG	Technical Working Group
UNZA	University of Zambia
USAID	United States Agency for International Development
WHO	World Health Organization
WISN	Workload Indicator Staffing Needs

ZEMA	Zambia Environment Management Agency
ZHWRS	Zambia Health Worker Retention Scheme
ZISSP	Zambia Integrated Systems Strengthening Program
ZMLA	Zambia Management and Leadership Academy
ZPCT II	Zambia Prevention Care and Treatment Partnership II

Executive Summary

The Zambia Integrated Systems Strengthening Program (ZISSP) continued working closely with the Ministry of Health (MOH) and the Ministry of Community Development, Mother and Child Health (MCDMCH) in 2013 to increase the use of high-impact health services through a health systems strengthening approach. This report presents ZISSP's performance progress during the period January 1st to December 31, 2013, the third full year of project implementation.

ZISSP's achievements showcase the project's whole-system approach that enables the MOH and MCDMCH to remove obstacles and strengthen the delivery and utilization of essential health services. The report outlines the key program achievements and the challenges experienced during implementation. Quantitative results are presented in Annex 2: The Performance Monitoring Plan. Highlights of achievements in 2013 include the following:

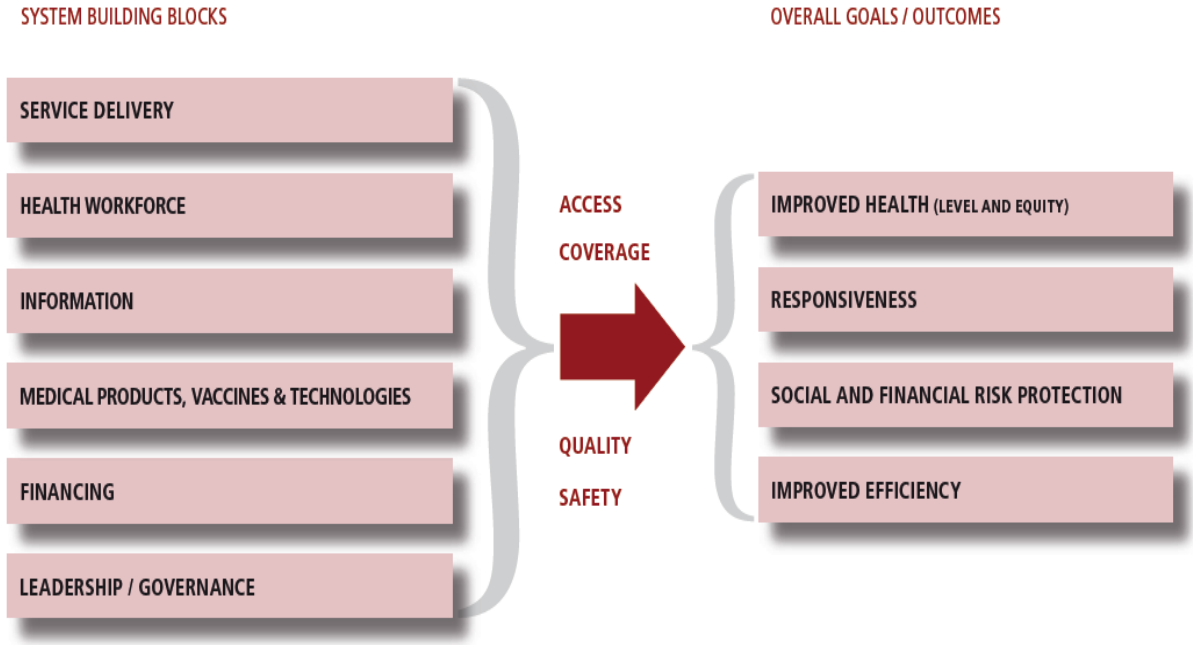
- Development of a customized MOH Human Resource Information System (HRIS), accompanied by the training of 46 HR staff and piloting at six health facilities.
- Finalized Zambia Health Worker Retention Scheme (ZHWRS) evaluation report, which will feed into the completion of the ZHWRS Sustainability Strategy in 2014.
- Mentorship of 1,987 frontline health workers (1,143 males, 844 females) in 2013, with 7,434 mentorship sessions conducted since project inception.
- Development of quality improvement (QI) project implementation tools; support for technical support supervision visits by the national QI Technical Working Group (TWG) to provinces.
- Progress in institutionalization of QI.
- Printing 19,600 QI job aides for the MOH QI committees at all levels.
- Developed the *Step-by Step Guide to Planning* and the *Simplified Guide for Community Planning*.
- Developed the *First Edition Data Quality Audit Guidelines*.
- Finalized the Resource Tracking Tool and accompanying database.
- Graduated the first 367 trainees from first ZMLA cohort, completed the mid-term evaluation of the ZMLA program, and developed Second Edition of the Zambia Management and Leadership Academy (ZMLA) training curriculum.
- Trained 523 health care workers (264 male and 259 females) in Infant and Young Child feeding and observed positive demonstration of child feeding counselling during mentorship visits in 11 districts.
- Trained 1,815 SMAG members (821 males, 994 females) in 2013. Since project inception ZISSP has supported training for 3,017 SMAG members (1,362 males, 1,655 females) in 17 districts.
- Disbursed K2,289,639.89 to ten grantees for various activities including training of SMAGs; training of CBVs as positive living advocates; engaging communities in planning; providing rapid diagnostic testing (RDT) and case management of malaria; and supporting FP. ZISSP also selected eight additional grantees that will receive support in 2014.

ZISSP's Finance and Administration, Gender and Capacity-Building, Knowledge Management and Monitoring and Evaluation (M&E) Units provided support to the various technical teams throughout 2013. Supportive activities included providing field-based financial support to grantees, building grantees' M&E capacities, completing success stories, upgrading the project database, and conducting gender orientation for Community Health Assistants.

Introduction

ZISSP's overarching goal is to work with the MOH and MCDMCH to nurture sustained improvements in management of the health system while also increasing the utilization of high-impact health services. ZISSP views health systems strengthening from the perspective of the World Health Organization's concept of six building blocks that comprise the system (**Figure 1**). ZISSP works to strengthen the individual building blocks and the linkages between the blocks. The intent is to improve the six health system building blocks and manage their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. In its work in each building block, the project seeks to address the drivers of health system performance: inputs, policies and regulations, organizational structure, and the behavior of health system actors.

Figure 1: WHO Health System Building Blocks



ZISSP works very closely with the MOH and the MCDMCH to support activities in the National Health Strategic Plan (NHSP) and annual action plan. In addition, ZISSP works at all levels of the health system – that is the national (MOH – Central Office), provincial, district and community – to build capacity to deliver high impact health services and to improve the use of health services.

ZISSP organizes its activities under the following four tasks:

Task 1: Strengthen the ability of the MOH[1] at the national level to plan, manage, supervise and evaluate delivery of health services nationwide.

Task 2: Improve management and technical skills of health providers and managers in provinces and districts in order to increase the quality and use of health services within target districts.

[1] This Task was later expanded to include strengthening MCDMCH after the reorganization between the two Ministries.

Task 3: Improve community involvement in the provision and utilization of health services in targeted areas.

Task 4: Ensure service delivery and other activities are effectively integrated at all appropriate levels in the health system through joint planning and in-kind activities with partners and appropriate public private partnerships.

ZISSP provides technical support and capacity building to the MOH and MCDMCH to enable the achievement of its program results. ZISSP focus areas include HIV and AIDS, malaria, family planning, and maternal, newborn and child health and nutrition. The program strengthens policies, resource management, and service delivery systems across these interrelated public health programs. As a result of ZISSP interventions, more families and individuals in selected districts in Zambia are expected to utilize the services and receive the information required for them to attain and maintain good health.

To achieve results under each task, ZISSP has adopted the following five main strategies:

- Use a whole-system approach to remove obstacles and strengthen the delivery and utilization of essential services.
- Build Zambian capacity as the foundation for sustainability.
- Increase impact through partner engagement and integration.
- Plan from the "bottom-up" in order to ensure relevance and participation.
- Ensure gender integration.

ZISSP is led by Abt Associates Inc., which works in partnership with Akros Research, the American College of Nurse Midwives (ACNM), Banyan Global, Broad Reach Institute for Training and Education (BRITE), the Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), Liverpool School of Tropical Medicine (LSTM), and the Planned Parenthood Association of Zambia (PPAZ).

1. Task one: Support for the Central Ministry

1.1 HUMAN RESOURCES FOR HEALTH

ZISSP set the following priority areas for human resources for health (HRH) in 2013, building on the work achieved in 2012 in partnership with the MOH:

1) Creating an enabling environment for optimal performance and productivity
2) Building human resource (HR) management and planning capacity
3) Expanding retention and attraction systems
4) Developing a modern human resource information system.

Creating an Enabling Environment for Optimal Performance and Productivity

The MOH has implemented the Performance Management Package (PMP) in the health sector since 2010 to improve accountability and efficiency in the public sector. In 2013, ZISSP provided financial and technical support to the MOH and to the Public Service Management Division (PSMD) to facilitate the implementation of a five-day training of trainers' (TOT) workshop on the PMP for the newly-created Muchinga Province. Ten trainers (7 males and 3 females), including the Provincial Medical Officer from Muchinga Province, were trained as trainers on the PMP. The trainers will facilitate the rollout of the PMP to all districts and health facilities in Muchinga Province, an activity supported by the MOH independently from ZISSP.

ZISSP also supports PMP technical support and monitoring activities. In June 2013, ZISSP supported two MOH teams to undertake PMP support visits to three provinces (Lusaka, Central and Luapula). The teams verified implementation of the PMP, evaluated work plans, and provided on-the-spot technical advice to facilitate the quick implementation and institutionalization of the PMP.

At the national level, ZISSP provided technical support towards enforcing and institutionalizing the PMP in the MOH by ensuring that all staff submitted their individual work plans for the year 2013. The Annual Performance Appraisal System (APAS), a component of the PMP, was used as a means for assessing staff performance. To complement the PMP initiative, ZISSP had planned to facilitate the development of a simplified handbook for terms and conditions of the civil service (with all appropriate policies and strategies) aimed at enhancing staff deployment, utilization and motivation. However, the handbook development activity lost relevance when the Government of Zambia began a process of reviewing and changing conditions of service, without a clear timeline for completion.

Following the training of 87 provincial staff as well as trainers on the WHO-designed Workload Indicators of Staffing Needs (WISN) tool in 2012, ZISSP provided technical support to the MOH in 2013 to hold a WISN orientation meeting for 28 participants (8 females, 20 males), including provincial medical officers, hospital medical superintendents and directors from the central MOH. Participants made a major decision to pilot the WISN in three health facilities in each province as a means towards better workforce planning for health facilities. The pilot commenced in the second quarter of 2013 at selected health facilities[2] in Mkushi and Kabwe Districts (Central Province). The ZISSP Management

[2] Kabwe General Hospital, Ngungu Urban Clinic, Kanyesha Health Post, Nkolonga Health Post and Chibefwe Urban Health Center.

Specialist for Central Province, in collaboration with Provincial Health Office (PHO) staff, participated in the data collection and analysis. The result of this exercise (which was completed in 2013 with a report anticipated in quarter 1 of 2014) will be the development of new staffing structures for the health facilities that participated in the pilot, which is expected to enhance their capacity to provide effective health services.

Building Human Resource Management Capacity

ZISSP supported the MOH's Directorate of Human Resources and Administration (DHRA) to train 31 registry clerks (13 females and 18 males) from the central and provincial levels of the MOH in a five-day records management training addressing gaps identified during previous capacity needs assessments. Gaps identified and addressed included security of information and understanding of the registry service manual. The training was facilitated by a combined team of senior staff from the PSMD under Cabinet Office and from the MOH Headquarters.

ZISSP had planned to support the training of senior management staff from DHRA in a high-level HR management and planning program offered at the Harvard Institute of Public Heath in the United States. However, this planned activity was cancelled at the request of the MOH, with reprioritization of funding towards the quarterly performance review meetings.

Expanding Retention and Attraction Systems

ZISSP continued to work with the MOH to improve the administrative and financial management of the Zambia Health Worker Retention Scheme (ZHWRS), aimed at populating the rural and hard-to-reach health facilities with professional staff. Out of the 1,400 available posts, a total of 999 staff (769 at MCDMCH and 230 at MOH) is in the scheme. Of these, ZISSP supports the retention allowances for 119 workers in the project's 27 target districts.

In 2013 ZISSP provided financial and technical support to the MCDMCH, following the realignment of the health sector components between the MOH and the MCDMCH. ZISSP recruited a Technical Officer posted at MCDMCH to facilitate capacity-building and efficient management of the ZHWRS. With ZISSP support, the MCDMCH audited the ZHWRS in Central, Northern and Luapula provinces, finding that 42 individuals had left their stations and were currently working at non-qualifying sites. The ZHWRS database was updated with this information.

ZISSP also supported the ZHWRS evaluation, which reviewed the performance of the scheme and recommended improvements. ZISSP and MOH, with support of Abt Headquarters staff, conducted data collection, entry and analysis. The evaluation report will be shared with all stakeholders during quarter one of 2014.

The ZISSP inception report on HRH noted that future sustainability of the ZHWRS was at risk due to lack of sufficient government funds to support the scheme and reliance on financial support from cooperating partners. In addition to providing insight into operations and challenges, the ZHWRS evaluation also provided useful information to guide development of a sustainability plan for the ZHWRS. Based on findings of the evaluation, ZISSP provided technical support to the MOH for production of Terms of Reference (TOR) to facilitate the development of the ZHWRS sustainability strategy. The information in the ZHWRS sustainability plan will provide guidance and direction to the MOH and MCDMCH on the future of the ZHWRS. A consultant has commenced the work on the ZHWRS

sustainability strategy as of December 2013, with a report expected in the first quarter of 2014.

Developing a Modern Human Resource Information System

Building on preparatory meetings in 2012, ZISSP provided financial support in 2013 to develop and pilot a comprehensive Human Resource Information System (HRIS) which can be used for storing employee data for manpower planning, general HR management functions and generating HR reports for decision-making. In 2013, eight senior Information Technology (IT) staff and four senior HR staff from MOH participated in a 14-day workshop that resulted in the development of a customized MOH HRIS system with an accompanying user manual. In August 2013, the developed system was presented to MOH management, which decided to pilot the system at selected health facilities prior to national roll-out, to train MOH HR staff on the HRIS.

ZISSP facilitated the training of 45 HR staff (20 females, 25 males) in the MOH HRIS from 11th to 17th August 2013. During this training workshop, six pilot sites were identified, namely: Ministry of Health Headquarters, Provincial Medical Office-Luapula Province, University Teaching Hospital (UTH), Kitwe Central Hospital, Monze Mission Hospital and Kabwe General Hospital.

In September 2013, ZISSP facilitated visits to the six identified sites by combined teams of HR and IT staff for the purpose of initiating the HRIS pilot. The teams oriented senior management and other key staff on the MOH HRIS, assisted with identification of interns for HRIS data entry, and installed the HRIS system at each site. ZISSP facilitated the temporal employment and deployment of the interns for different durations, depending on the workload at each site. Following completion of data entry exercises in November 2013, ZISSP supported HR and IT team visits to the six sites to merge the databases, collect information on system bugs, and discuss challenges experienced with the system. The system is currently being updated and "perfected" prior to the 2014 rollout.

Strengthening Human Resources at Central Level

ZISSP provided technical and financial support to the MOH's DHRA to hold two quarterly performance review meetings. (From 2011, the DHRA decided to include departmental quarterly performance review meetings in the ZISSP work plan as part of a process for systems strengthening.) The meetings enabled the DHRA to evaluate the department's mission and strategic goals and to assess and monitor its own performance against the yearly work plans and the performance targets in the Human Resources for Health Strategic Plan (HRHSP) (2011 – 2015). The meetings produced positive results, such as:

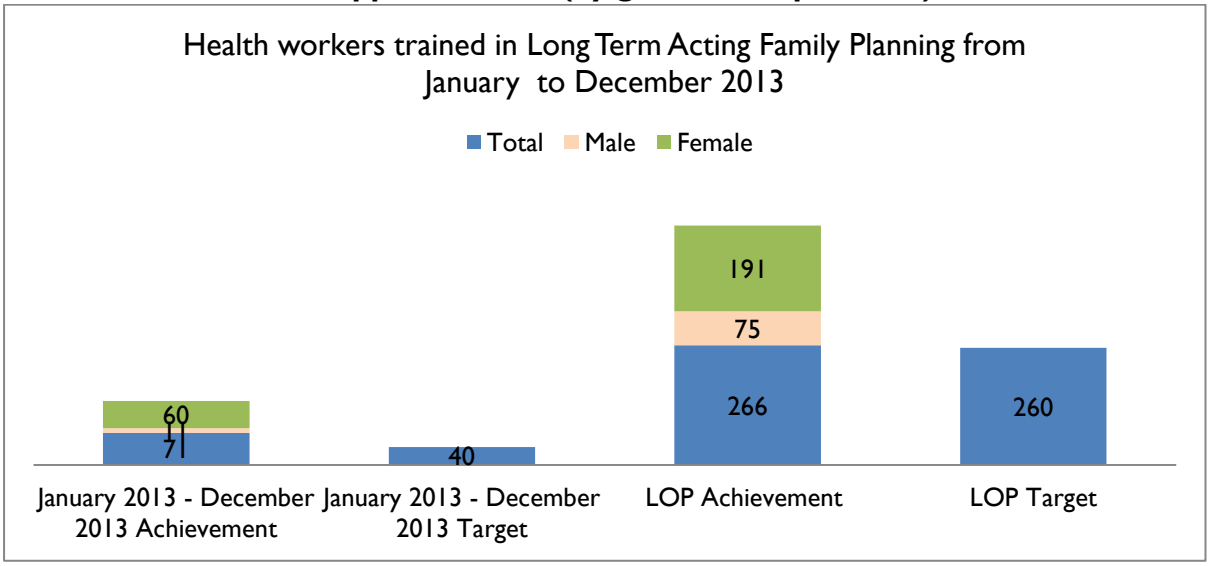
- HR staff was introduced to a quarterly reporting template, developed by the ZISSP HRH Specialist, which resulted in the production of more focused reports.
- The DHRA has improved effectiveness and timeliness of ad hoc and routine progress reports.
- The meetings improved teamwork due to increased interaction amongst HR practitioners who previously did not know each other on a personal level.
- The DHRA has improved knowledge -sharing and productivity.
- The DHRA received a letter of commendation from the Commission Secretary, Public Service Commission at Cabinet Office, for the notable effective and efficient processing of HR cases in the ministry.

ZISSP supported the MOH to hold five HRH Technical Working Group (TWG) meetings in 2013 to consolidate consensus of the MOH decision-making in terms of the HRHSP and to strengthen communication lines between various stakeholders working in HRH. The 2013 HRH TWG members deliberated on various HRH issues, including the need to conduct a mapping exercise to document all the HRH stakeholder activities in Zambia. ZISSP supported the development of a mapping tool for this exercise. The HRH TWG also served as a forum for sharing and reviewing the ZHWRS evaluation report and the National Training Operational Plan 2013 – 2016, leading to finalization of both documents.

1.2 FAMILY PLANNING

Expand Access and Use of Long-Acting Family Planning Services: From January to December 2013, ZISSP provided financial and technical support to MCDMCH to train 71 health providers (11 males, 60 females) in long-acting family planning (LAFP) method provision against a target of 40 (**Table 1**). Trained participants comprised 19 nurse tutors and clinical instructors and 52 health workers from 17 districts[3]. A total of 266 (75 males, 191 females) have been trained against a target of 260 in 32 districts (24 ZISSP-supported plus eight other districts). Participants have since recommended the inclusion of Maternal Child Health (MCH) Coordinators in future LAFP trainings to facilitate effective supervision of trained health providers in the provision of FP services.

Table 1: Nurse tutors, clinical instructors and health providers trained in LAFP methods with ZISSP support in 2013 (by gender and province)



In 2013, ZISSP financially supported the MCDMCH to provide post-training follow up to 63 health providers in 10 districts across three provinces (Eastern, Central and Southern). The visits assessed the retention of knowledge and skills and provided an opportunity for on-going technical support. Two success stories were written on the integration of LAFP into nursing and midwifery training schools. ZISSP also identified challenges faced in the provision of LAFP methods. Trained healthcare providers reported non-availability of commodities in some districts; limited availability of basic equipment and instruments to provide LAFP

[3] Copper Belt Province (Lufwanyama, Masaiti, Luanshya, Kitwe); Central Province (Kabwe); Lusaka Province (Chongwe, Luangwa, Lusaka); Northern Province (Mbala, Kasama); Muchinga Province (Mpika); Western Province (Shangombo); Eastern (Chipata, Katete); Luapula (Kashikishi) and Southern (Monze).

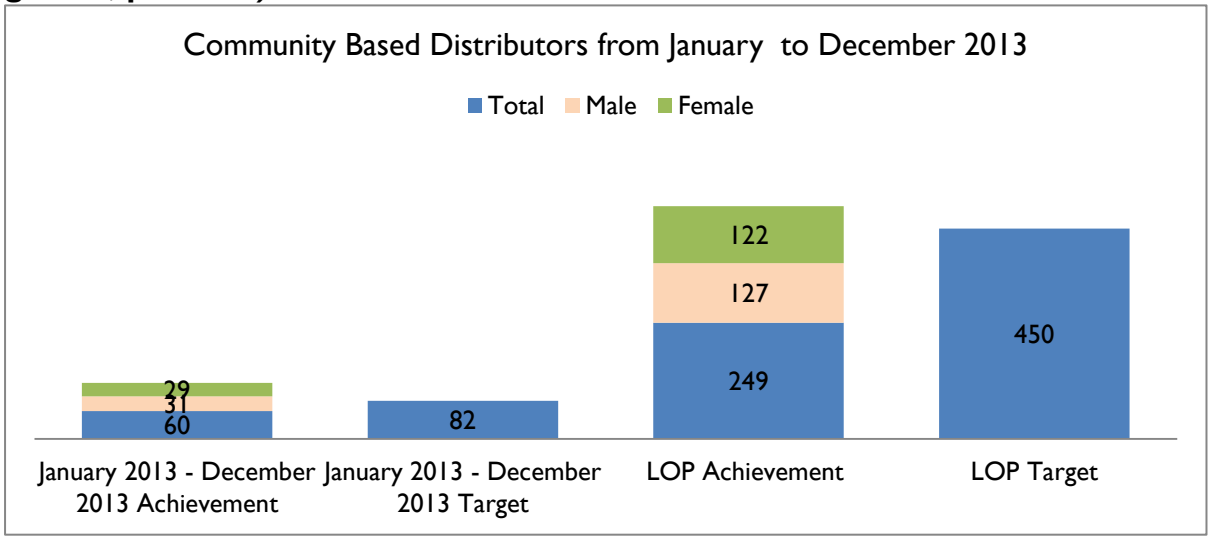
services; and limited availability of training models (Madam ZOEs and training arms to facilitate practicum sessions). The planned follow-up of 37 additional trained health providers, scheduled for December 2013, was rescheduled to January 2014 following a directive from the Permanent Secretary that no activities be implemented from 17th December 2013.

With support from the Capacity-Building Unit, ZISSP prepared and submitted a concept note on integration of LAFP methods into the pre-service nursing and midwifery training curriculum to the General Nursing Council of Zambia (GNC). With ZISSP financial and technical support, the GNC invited 46 experts to a meeting to discuss strengthening of the LAFP component in the midwifery training school. The agreed the way forward included continuation of capacity building of nurse tutors and clinical instructors in LAFP methods; review of midwifery curriculum to strengthen the LAFP methods component; and procurement of basic equipment and training models by ZISSP for the skills labs at three midwifery training schools.

ZISSP faced delays in the planned review of the FP and Community-Based Distributors (CBD) training manuals and review of the national FP guidelines and protocols for service delivery. These activities depended on the availability of MCDMCH senior staff to provide policy guidance, but the senior staffs were often committed with other national duties. Other planned activities at provincial and district levels were rescheduled as they coincided with activities prioritized by the national MCDMCH (e.g., planning launches, Child Health Week, etc.)

Expand Access to and Use of Community Based Distribution Services: ZISSP financially and technically supported three, 10-day trainings of 60 community volunteers (31 males, 29 females) as CBDs against a target of 82. They came from Mwinilunga (North-Western Province) and Sinazongwe and Gwembe Districts (Southern Province). The training equipped participants with knowledge and skills to provide community-based FP services (distribution of oral family planning methods and condoms). To date, ZISSP support has enabled the MCDMCH to train 249 (127 males, 122 females) CBDs against a target of 450 from 13 districts (**Table 2**).

Table 2: Community-Based Distributors trained with ZISSP support in 2013 (by gender, province).



Post-training visits were conducted to assess to what extent the new skills were used by 111 CBDs from six districts in three provinces (Northern, Muchinga and Eastern). During these visits, challenges in providing quality CBD services included lack of transportation for CBDs in rural areas and lack of basic support requirements, e.g., information, education, Communication (IEC) materials, stationery, storage facilities, identification cards, raincoats and gum boots. Stock-outs of contraceptive commodities in some districts demotivated some CBDs as they could not do their jobs. In cases where District Medical Officers have not shown ownership of the CBD program (mainly due to not having a strong understanding of the program), there is a lack of supervision of the CBDs at district and/or health facility levels.

ZISSP has learned that orienting managers at provincial, district and health center levels on the program prior to activity implementation can foster ownership of the program. In 2013, ZISSP supported development of orientation and supervision packages that are currently with MCDMCH for editing. The planned validation of these packages by the FP TWG has been re-scheduled for January 2014. Two related activities did not take place as planned in December 2013: the orientation of 50 managers on the CBD program and the training of 50 health providers as CBD supervisors. The delay was due to a directive from the Permanent Secretary of MCDMCH that no activities should be implemented from 17th December 2013 until January 2014 to enable staff at provincial, district and health facility to take leave while many partners were on holiday recess.

1.3 ADOLESCENT HEALTH

To contribute to the improved health status of adolescents, ZISSP continued to support the MCDMCH to train and mentor healthcare workers and peer educators on adolescent health (ADH). In 2013, ZISSP provided financial and technical support to the MCDMCH to consolidate the peer education training manuals into a standardized National Peer Education Training Package. The package was finalized in December 2013 with support of the ZISSP Technical Writer before submission to MCDMCH for its endorsement, anticipated in 2014.

With ZISSP technical and financial support, the Adolescent Health TWG developed the national Adolescent Health Communication Strategy, which has been approved by the MCDMCH, and the Adolescent-Friendly Health Services Standards and Guidelines, which are awaiting approval from the MCDMCH. Both documents will support implementation of the overall strategic plan. The launch of these is expected in March 2014.

In 2013, ZISSP supported the MCDMCH to train 25 healthcare providers (16 males, 9 females) in ADH. ZISSP also supported training for 57 peer educators (28 males, 29 females) in sexual and reproductive health and rights and HIV prevention strategies. Peer educators came from 11 health facilities in Mpika District (in addition to the 27 facilities supported in Nakonde and Mpika). The training equipped the participants with the knowledge and skills on how to improve health service delivery for adolescent clients. To create a pool of peer education trainers, ZISSP supported the training of 19 provincial peer education trainers from ZISSP-supported districts across ten provinces. Trained peer educators are linked into government structures, including health centers, District AIDS Task Force committees and Youth Friendly Centers under the Ministry of Youth and Sport.

1.3 EMERGENCY OBSTETRIC AND NEONATAL CARE

Emergency Obstetric and Neonatal Care Training: In 2013, ZISSP supported the Emergency Obstetric and Newborn Care (EmONC) training of healthcare providers from eight districts and four general hospitals. ZISSP has cumulatively trained 334 healthcare workers (143 males, 191 females) in 31 districts (including non-ZISSP districts) since project inception, against the life of project target of 340.

The EmONC training equips healthcare workers with the knowledge and skills to identify complications, make appropriate referrals and manage emergency maternal and neonatal conditions, thus contributing to the reduction of maternal and neonatal morbidity and mortality.

Photo 1: Mr. Watson Chiyabi is a Registered Nurse working at Chaamwe Rural Health Center in Gwembe District. After training as a nurse, he chose to go and work in his home village. Eleven months into his profession he was trained in EmONC. During a technical support supervision visit, the ZISSP team observed Watson conduct a delivery.
After the delivery, Watson said, "I really appreciate the EmONC training. It has given me the confidence to work among my own people. They feel safe with me and they come to deliver here. The deliveries have increased. I am not a midwife but now I have the confidence to deal with maternity cases."

Technical Support Supervision: ZISSP supported EmONC trainers to conduct post-training technical support supervision (TSS) for 64 EmONC-trained healthcare providers in Lusaka, Southern, Luapula, Muchinga and Northern Provinces. The post-training visits assessed the implementation of the acquired new knowledge and skills, identified areas that needed mentorship, and were used to document success stories. Visits revealed that EmONC-trained providers at health center level are able to perform a number of procedures that would have required higher-level referral prior to the training (such as breech delivery). The use of magnesium sulphate has increased, and case management protocols have been written and displayed. The biggest problem is the lack of equipment to match the application of newly-acquired skills.

In collaboration with ACNM, ZISSP supported the MOH to initiate development of a supportive supervision system for EmONC training sites. The objective of developing this system, which will be finalized in 2014, is to strengthen EmONC activities at training sites; to maintain open communication between the hospital staff and the EmONC training team,; to support the hospital to maintain and improve standards of care so that the environment is conducive for training; to assist healthcare providers to integrate EmONC protocols and skills; and to conduct regular assessments of the hospital to ensure that the standard of practice remains in line with EmONC training content.

Misoprostol: In 2013, ZISSP was unable to proceed with the plan to orient health providers in the use of Misoprostol for the prevention of postpartum hemorrhage in Zambia due to lack of the commodity. However, measures to procure the commodity have been put in place and ZISSP will embark on the orientation of health care providers as soon as the commodity is available.

Strengthen Midwifery Services: In 2013, ZISSP and ACNM provided financial and technical support for two separate visits for skills lab management training to three Direct Entry Midwifery schools (Roan, Nchanga and Chipata). The visits monitored the correct application of the knowledge and skills acquired by tutors and clinical instructors. Three additional midwifery schools (Livingstone, Chilonga and Ndola) had their skills labs upgraded in 2013 through the provision of models and equipment. Since project inception, six schools have received this type of support, with plans to add three more schools in 2014.

1.4 CHILD HEALTH

Integrated Management of Childhood Illnesses: In 2013, ZISSP supported the MOH and MCDMCH to build the capacity of healthcare workers in Integrated Management of Childhood Illnesses (IMCI) through training and post-training follow-up visits for 122 healthcare workers. ZISSP has now cumulatively trained 570 (296 males, 274 females) health workers in IMCI in 25 (out of 27) target districts since project inception. Through these trainings, ZISSP contributed to seven[4] districts reaching the desired saturation level of 75% - 80% of health facilities with at least one health worker trained in IMCI.

ZISSP also supported the IMCI post-training follow-up visits to 88 (of 97) healthcare workers from eight districts to assess their strengths and weaknesses in IMCI service delivery and provide on-site supportive supervision where necessary. Results of post-training follow-up show improved practices in assessment, classification and treatment of sick children. Areas of improvement include counseling on nutrition and drug management for improved home management of sick children, including recognition of signs that indicate a need for further care at facility level.

In 2013, ZISSP supported training of 24 nurse tutors (16 males, 8 females) in the IMCI Computerized Adaptation and Training Tool (ICATT), a computer-based IMCI training package. Since project inception, 48 nurse tutors (29 males, 19 females) have received training in ICATT. Ninety percent of nurse training institutions now have at least three tutors trained in ICATT.

[4] Kalomo, Gwembe, Sinazongwe, Kalabo, Lukulu, Shangombo and Mkushi districts.

Photo 2: Mrs Eunice Malama, the Principal Tutor at Chipata School of Nursing, said, "All pre-service trainers appreciated the application of ICATT in teaching IMCI to pre-service students and wished the ICATT training player would be extended to other technical areas such as reproductive health, nutrition, HIV and AIDS. The training approach has addressed the nightmares faced by many schools in teaching IMCI to large numbers of students and will save us a lot of training costs which are paid toward hiring facilitators. This training has increased my passion in teaching IMCI. I was discouraged to teach large numbers of students, but now I am highly motivated to facilitate IMCI to large numbers and improve health outcomes of sick children".

ZISSP supported an assessment on the functionality of existing Oral Rehydration Therapy (ORT) corners and the feasibility of providing comprehensive child health services. When a child presents with diarrhea at a health facility, every opportunity of a child's contact with the health facility must be utilized to optimize the child's health. The establishment of Oral Rehydration Therapy (ORT) Corners within the health facility is a proven approach to ensure each child receives treatment for dehydration for diarrhea. The ORT Corner is an area within a health facility where caregivers can easily access life-saving rehydration for sick children. Sick children receive ORT from their caregivers under the supervision of a trained service provider with a minimum observation period of four hours. At the end of the observation period, the service provider assesses the child's condition and makes recommendations based on the child's status. Studies have shown that after treatment in an ORT corner, the majority of children will recover sufficiently to be sent home . The ORT Corners also provide opportunity to integrate additional child survival interventions to reduce child mortality. Not only do ORT corners enable adequate management of dehydration in diarrhea, but caregivers are also taught how to make ORS and how to administer it, which strengthens their ability to rehydrate a child competently at home. The study found that ORT Corners had the potential to be revitalized with low-cost technological inputs, appropriate skills training and task-shifting with supervision.

Based on these findings, ZISSP supported the training of 20 health workers (9 males, 11females) and 30 Classified Employees (CEs) and community health workers (CHWs) (15 males, 15 females) in ORT Corner management. Strengthening the ORT Corner concept by providing comprehensive child health services was highly appreciated by mothers with sick children and by facility providers. Tebia Kambulu, an Enrolled Nurse from Namwianga Rural Health Center, remarked, "The improved management approach through the ORT Corner strengthening has improved caretaker confidence to care for sick children at home."

Photo 3: Mrs Lydia Liseli, a mother, administers oral rehydration solution (ORS) to a three-year-old child with diarrhoea and dehydration at Namwianga Rural Health Center, Kalomo District.

Expanded Program on Immunization: In 2013, the national immunization coverage was challenged with erratic supplies of vaccines, inadequate cold chain maintenance practices and postponement of outreach activities resulting from inadequate and untimely disbursement of financial resources to the districts. To address these challenges, the MOH and MCDMCH supported efforts to build the capacity of health facility staff and community volunteers in the Reaching Every District (RED) Strategy, which aims at reaching every child in every district with a package of child health interventions.

In 2013, ZISSP supported RED Strategy training for 169 health workers (96 males, 73 females) and 105 Community Health Workers (CHWs) (65 males, 40 females) from Southern, Western, and Lusaka Provinces to improve the tracking of children for immunization services. This exceeded the annual targets of training 70 healthcare workers and 100 CHWs, respectively, and brought the cumulative total to 259 healthcare workers (124 males, 135 females) trained in the RED strategy since project inception. Post-training follow up visits in Western and Southern provinces revealed the following:

- Positive efforts were made in defining target populations living in hard-to-reach areas, but more effort was required to improve implementation of activities and strategies for them.
- All the CHWs had established Community Child Health Registers and had commenced the registration process of children under five years of age. CHWs recorded child health and women in child-bearing age interventions provided to households with pregnant women and children under five. Commonly-cited use of Community Child Health Register information included defaulter tracing and follow up, and activity plan development. The information collected assisted facility health workers with appropriate estimation of required supplies and logistics for immunization service.
- Ten out of 20 health facilities visited displayed Immunization Monitoring Charts, which illustrates facility-level performance in immunization services. Areas that needed further strengthening include emphasis on the practice of frequently updating the chart, correct charting and use of the chart to monitor immunization coverage.

Scale-up Newborn Care: The year 2013 was characterized by important milestones for the scale-up of newborn care activities, including the completion and dissemination of the *Newborn Care Scale up Framework and Guidelines* to key national level stakeholders and the completion of the final draft of the *Essential Newborn Care Guidelines*. The participation of the Zambian delegation in the Global Newborn Health Conference in Johannesburg, South Africa renewed the stakeholders' interest to support activities for scale-up of newborn care.

Photo 4: Mary Kaoma of ZISSP presented a poster on the "Assessment of the Baby Friendly Health Facility Initiative in Zambia" at the 141st American Public Health Association (APHA) conference in Boston in November 2013.

1.5 NUTRITION INTERVENTIONS

Infant and Young Child Feeding Training and Mentorship: With ZISSP support, the MOH and MCDMCH trained 468 healthcare workers (238 males, 230 females) and 730 community volunteers (358 males, 372 females) in Infant and Young Child Nutrition (IYCN) and Community Based Growth Monitoring by December 2013 since inception of ZISSP. The training focuses providing the health workers with required knowledge and skills to counsel caretakers of children under the ages of two years on how to prevent malnutrition through the provision of nutrition-focused support, emphasizing child feeding.

ZISSP supported post-training mentorship for 61 healthcare workers and 146 community volunteers in Lundazi, Luangwa and Mwinilunga, Masaiti, Chiengi and Nchelenge Districts. Both the health workers and the community volunteers demonstrated the appropriate skills and knowledge in IYCF as they counseled clients with infants and young children.

Photo 5 (above): A health worker prepares food during a cooking demonstration at the IYCF training.

Photo 6: Beatrice Nyirongo, a trained volunteer in IYCF, listens to a mother as the mentor looks on during the IYCF TSS visit.

Photo 7: A mother is provided encouragement to breastfeed.

Vitamin A Supplementation and Deworming: ZISSP supported MCDMCH and the National Food and Nutrition Commission (NFNC) in the monitoring and supervision of the two rounds of Vitamin A supplementation that were conducted in July and December 2013 in seven provinces (Southern, Lusaka, Central, Copperbelt, Luapula, Western and Eastern). ZISSP also supported the bi-annual Child Health Week, which provides Vitamin A supplements, growth monitoring and deworming activities for children under five years of age.

Photo 8: An infant receives Vitamin A during Child Health Week.

Support to World Breastfeeding Week: ZISSP supported the 2013 World Breastfeeding Week launch in Mwanse community (Lundazi District). The launch reached approximately 100 community members with high-impact, effective messages on sustainable and successful breastfeeding and optimal complementary feeding practices. Communication methods included a phone-in program on the local radio station, drama performances, songs and dance.

Photo 9: School pupils of Mwanse Lundazi march past during Breastfeeding Week.

Photo 10: A local drama group performs during the launch of breastfeeding week in Lundazi.

Support to the National Food and Nutrition Commission: ZISSP supported the NFNC to develop maternal, adolescent, infant and young child nutrition (MAIYCN) training packages. ZISSP supported two stakeholder meetings to review and update the current draft guidelines on MAIYCN, focusing on the "1000 Most Critical Days" program. ZISSP also supported the NFNC to conduct orientation meetings, mapping and a gap analysis in the 14 inception districts for the "1000 Most Critical Days" program. Through this process, integrated district nutrition plans were developed by all the districts and among the Scaling-Up Nutrition (SUN) government ministries of focus (MOH, MCDMCH, Ministry of Agriculture, Ministry of Education, and Ministry of Local Government). ZISSP supported the MCDMCH and NFNC to facilitate SUN site visits to Chongwe, Chipata and Mumbwa districts. The site visits included a demonstration of key "1000 Most Critical Days" activities that ZISSP and other United States government projects support in these three districts. During the site visit, Mrs Eustina Besa (head of the Communication Department at NFNC), was amazed with what she observed. She said, "The community level was full of innovations, and if at all what we saw could be taken to scale, then Chipata is on its way to reducing child malnutrition and poverty."

II. Task Two: Support to the provinces and districts

2.1 QUALITY IMPROVEMENT AND CLINICAL CARE

The clinical care team set the following two priority areas for 2013:

1) Institutionalizing quality improvement at all levels of the health care system.
2) Institutionalizing clinical care mentorship in health service delivery.

2.1.1 Quality Improvement

Institutionalization of quality improvement (QI) within the MOH will only be a reality once the structures are established at all levels in line with the national QI operational guidelines launched by the MOH in 2012. These structures will enhance sustainability of quality improvement in health service delivery.

National Quality Improvement Steering Committee: In 2013 ZISSP planned to facilitate the formation of a national QI Steering Committee as per the 2012 MOH operational guidelines. The Steering Committee would be responsible for providing policy direction, leading advocacy and guiding resource mobilization for QI programs, and assigning responsibilities (as needs arise) to the national QI TWG. ZISSP proactively pursued this initiative in 2013. A breakthrough in progress occurred when the MOH Directorate of Clinical Care and Diagnostic Services brought the agenda to the Permanent Secretary in November, followed by the assignment of the Deputy Director to facilitate the process of identifying the list of members. ZISSP supported the Deputy Director with his newly assigned mandate by sensitizing him on the benefits of establishing the national QI Steering Committee. Once active, the committee will hold quarterly meetings chaired by the Permanent Secretary and include directors of various MOH health programs, cooperating partner representatives, and funding agencies. In quarter four, ZISSP also held a consultative meeting with the new director for Clinical Care and Diagnostic Services, who instructed his deputy to facilitate this process in the first quarter 2014.

Support to Quality Improvement Technical Working Group: ZISSP actively participated in and supported the quarterly QI TWG meetings in 2013. Meeting participants discussed strategies for the institutionalization of QI. TWG members also discussed progress toward finalization of the QI training package, which, although developed in 2012 and currently in use, required restructuring of the manual content. A consultant (hired by ZISSP) has since completed the review of the QI training package, which has been ratified by the QI TWG and awaits editing and formatting before the final printing.

Following the series of country-wide QI trainings in 2012, the main priority in 2013 for the national QI TWG was to facilitate the formation of QI committees at all levels in the provinces. This process started with the formation of provincial QI committees, which provided guidance to the formation of district QI committees, which in turn facilitated formation of QI committees in health facilities. To equip the QI committees with skills to identify and effectively implement QI projects, the QI TWG developed tools to facilitate the operationalization and uniformity of QI programs and reporting (QI project implementation, supervision, monitoring, evaluation tools and a format for documentation of their meeting proceedings).

ZISSP facilitated TSS by the QI TWG to all ten provincial QI committees, including visits to some district and health facility committees. The MOH funded this activity for two provinces, which is a step towards government ownership. During these visits, the QI TWG oriented and coached QI committee members on their roles and responsibilities with a focus on the following core skills: (1) identification of quality gaps in health service delivery; (2) initiation and implementation of QI projects; (3) monitoring and evaluating QI; (4) documenting achievements; and (5) sharing best practices. In the same way the national QI TWG provided TSS to the provincial QI committees, the provincial QI committees provided capacity-building to the lower-level committees to enhance institutionalization of QI process in health service delivery.

The QI TWG shared the five QI core indicators with all the QI committees as the key indicators that will be monitored and evaluated by the national QI program (**Figure 2**). QI committees are also able to develop QI projects relevant to their unique health institutions in addition to those QI initiatives related to the five core indicators.

Figure 2: Five key QI indicators identified by the MOH:

1. Percentage of exposed infants tested for HIV at 12 months.
2. Percentage of all HIV positive clients retained on ART over the last 12 months.
3. Number of maternal deaths at the facility recorded in the last one month/quarter/12 months.
4. Proportion of confirmed malaria cases in the last one month/quarter/12months.
5. Number of under-five children who died in the last one month/quarter/12 months.

The 2nd Annual National QI Conference: In September 2013, ZISSP supported the MOH, through the QI TWG, to successfully host the 2nd Annual National QI Conference under the theme *Institutionalizing Quality Improvement in Health Service Delivery*. ZISSP leveraged resources to co-fund the conference (with MOH, Centre for Infectious Disease Research Zambia [CIDRZ] and HealthQUAL International USA). Over 150 delegates attended, representing all levels of the health system across the 10 provinces.

The submission of sixteen abstracts, which exceeded expectations by the conference organizers, to the conference by established QI committees demonstrated progress in the institutionalization of QI. Conference presenters included QI experts from the MOH, Health Practitioners Council of Zambia (HPCZ), Centers for Disease Control and Prevention (CDC), and ZISSP. Selected health facilities presented case studies on QI projects they were implementing, including Choma General Hospital ("Use of Quality Improvement Analytical Tools for Problem Solving") and Lundazi District Hospital ("Improving Obstetric Care through Use of Completed Partographs"). Accepted abstracts at the conference described QI activities that were implemented in various health facilities across Zambia, including "Reduction in the Incidence of Neonatal Sepsis" (Lewanika General Hospital, Mongu), "Improving Clients' Waiting Time" (Monze ART clinic), "Strengthening Laboratory Support System to Improve Patient Case Management" (Livingstone General Hospital), and "Using Quality Improvement Approach to Reduce 'Lost to Follow-up' of Pregnant Mothers" (Mtendere Mission Hospital/AIDSRelief).

Following the conference, the focus of the QI TWG returned to supporting the formation of QI committees. For example, the Lusaka provincial QI committee offered technical support to the formation of a QI committee at Luangwa District Health Office and for activation of QI committees at both the University Teaching Hospital (UTH) and Levy Mwanawasa Hospital. At UTH the Deputy Medical Superintendent will chair the meetings,

comprised of all departmental heads, and each department will form QI sub-committees. This approach, with clear organizational support from the beginning, is expected to result in stronger ownership by management. However, a remaining challenge is that most QI committee members have yet to be trained in QI.

Decentralization of QI Training: ZISSP continued to support the decentralized training of health workers in QI through the MOH, i.e., 449 health workers (266 males and 183 females) from ten provinces in QI with ZISSP support. The 449 included 64 provincial trainers. In addition, 30 health workers have also been trained (gender unclassified). The annual target of 250 was exceeded because some health facilities could not form a QI committee because not enough of their health workers had been trained in QI. The MOH did not allocate sufficient funds for QI training in 2013. As a result, some ZISSP resources were reprogrammed from funds budgeted for QI TSS to QI committees. The trainings enhanced institutionalization of QI in health service delivery.

ZISSP has cumulatively trained 1,028 health workers in QI (610 males, 418 females) from inception of ZISSP. Several other MOH cooperating partners have also trained health workers from health facilities under their support in QI. Despite large numbers of health workers trained nationwide, most health facility QI committees have only one or two members trained in QI. In some facilities this training gap results in challenges for the committee to effectively initiate and implement QI projects.

Development of Quality Improvement Job Aids: In 2013, the QI TWG, with ZISSP's coordination, developed the following QI job aides to further strengthen QI committee operations:

1. Performance Improvement Approach Framework (4,200 copies printed)
2. Flow Chart (4,400 copies printed)
3. Fishbone Analysis (5,000 copies printed)
4. Five National QI Core Indicators (6,000 copies printed)

The QI job aids have been ratified by the QI TWG, and ZISSP supported MOH to print 19,600 copies. The tools will be distributed to QI committees at all levels to enhance operationalization and sustainability of QI to support health service delivery.

At the MOH's request, ZISSP supported three MOH consultants from UTH to participate in the development of National Clinical Care Audit Guidelines. The ZISSP Clinical Care Specialists (CCS) from Central and Southern Provinces and the Clinical Care Team Leader participated in the exercise, providing technical guidance on the standards.

Maternal and Under-Five Mortality Reviews: In recognition that most health workers in the provinces have limited death review skills and knowledge, ZISSP supported the provincial and district QI committees to facilitate mortality reviews in 2013 as a QI strategy. Among the five MOH QI core indicators, two (maternal and under-five mortality) were selected on the basis of their direct reflection of the quality of clinical case management at any level. QI committees will use mortality data as an entry point to identify performance gaps for QI projects.

ZISSP provided both logistical support to provincial and district structures to facilitate these mortality reviews in nine provinces (all but Copper Belt), in which the QI committees collaborated with the provincial and district Clinical Care Teams (CCTs) for mentorship. ZISSP facilitated participation in the maternal death review in all the health facilities and with

staff that attended to the specific cases (deceased women) spanning antenatal, labor and post-natal periods up to the time of the maternal death.

ZISSP also supported four provinces (Central, Muchinga, Northern and North-Western) to conduct joint case reviews with their respective districts. These meetings strategically built district-level capacity to objectively review their own maternal mortality cases and to identify appropriate interventions to improve performance. The case review process revealed important capacity gaps. Muchinga and North-western Provinces reported 28 and 17 maternal deaths, respectively, between January to June 2013. Central Province had a maternal mortality ratio (MMR) of 500/100,000 live births (2010 census), the third highest in the country and above the national average of 483/100,000. The Central Province review (facilitated by a specialist from UTH) found that nurses and midwives at delivery centers in Kabwe District had inadequate skills and knowledge to stabilize or manage cases of hypertensive disorders in pregnancy before referring to Kabwe General Hospital.

Hemorrhage generally topped the list of causes of maternal mortality in all provinces. Other causes included puerperal sepsis, malaria and hypertension in pregnancy. Health systems factors contributing to maternal deaths included the following: lack of focused antenatal care in most of the referral health centers; home deliveries by untrained traditional birth attendants (TBAs) (some of whom were administering herbal drugs); unskilled health attendants; lack of clear communication mechanisms for referrals; and delayed consultation and referral by the health provider.

Central, Southern and Western Provinces reported on the review of some neonatal and under-five mortality cases. Despite maternal mortality reviews being conducted in public health facilities on the Copper Belt Province, there was no documentation to show ZISSP support to this activity through the provincial QI committee.

Evaluation of the Provincial Review Meetings: Provincial quarterly performance reviews previously supported by ZISSP in 2011 and 2012 served as a forum to build the analytical skills of health program managers and enhance the use of health facility information for decision-making. Following concerns over the value addition of this activity to QI in health service delivery, ZISSP engaged a consultant to evaluate the effect of the provincial quarterly review meetings to enhance effectiveness of the meetings in terms of building participants' analytical skills. This evaluation was done in collaboration with the ZISSP Monitoring and Evaluation (M&E) team. The evaluation has been completed and a report submitted to ZISSP, but has not yet been shared with the MOH. Details of the findings will be reported in first quarter 2014 after MOH review.

Survey on Anti-Retroviral Therapy (ART) Accredited Health Facilities: In 2012, ZISSP supported the Health Practitioners Council of Zambia (HPCZ) to conduct a knowledge, attitudes and practice (KAP) survey of the ART accreditation program. However, the data collected had some inadequacies. In response, HPCZ developed a set of new data collection tools with full participation from ZISSP and the consultant. ZISSP worked with HPCZ to finalize the report. The findings will be disseminated in quarter one of 2014 once the report is finalized.

Clinical Care Health Systems Strengthening Support Impact Evaluation: ZISSP drafted a concept paper in quarter four of 2013 to measure the effectiveness of QI activities, including clinical mentorship, in producing positive outcomes of the five MOH QI core indicators in the model health facilities. The study will be conducted in 2014. This study is

part of ZISSP's exit strategy to address sustainability of the QI and mentorship programs. Evidence generated from this evaluation will help the QI Unit at the MOH to review the two programs, and use results to inform policy. Results will be used to influence a commitment by MOH and MCDMCH to fund scale-up of QI strategies (including mentorship) and create QI positions at provincial and district levels.

Support to Performance Assessment and Technical Support Supervision: In 2013, ZISSP provided financial support for eight[5] CCSs to provide technical assistance for the biannual Performance Assessment that was conducted by all provinces in selected health facilities across all districts. The CCSs provided technical assistance in assessing health service delivery in clinical areas. Key findings at some facilities included:

- Challenges in providing FANC due to supplies shortages (e.g., blood pressure machines, Hemocues for testing Hb)
- Lack of integration of infection prevention measures into health service delivery
- Increases in TB cure rate
- Decreases in maternal deaths
- Marked improvement in malaria case management as a result of mentorship
- Identified need for increased use of partographs
- Improved adherence to treatment protocols
- Non-functional chemistry analyzers in laboratories had negatively affected the quality of monitoring patients on ART.

Identified gaps were followed up with appropriate technical support, including clinical mentorship and other QI strategies.

2.1.2 Institutionalization of Clinical Care Mentorship

In 2013, clinical mentorship was the second priority area of ZISSP support to the MOH and MCDMCH under clinical care. To institutionalize clinical care mentorship for QI in health service delivery, the Clinical Care Unit at ZISSP supported MOH to implement the innovation to decentralize mentorship through the establishment of multi-disciplinary CCTs at all levels. The process emphasized needs-based clinical mentorship to identify the performance gaps requiring mentorship across various clinical fields and support functions.

Formation of the National Clinical Care Team for mentorship: ZISSP took proactive steps in 2013 to influence the formation of a national-level multi-disciplinary CCT to support and provide specialized mentorship to the provincial and district CCTs. Despite challenges, ZISSP organized and had an advocacy meeting with the new MOH Director of Clinical Care and Diagnostic Services resulting in a letter, which included a list of names and organizations, being submitted to the Permanent Secretary for his authorization by the Director to establish the national CCT.

Development of Treatment Flow Charts and Job Aides for mentorship: In 2012, ZISSP's plan was to support the MOH with developing treatment protocols for common health conditions and equip the mentors and health service providers in health facilities with these. However, staff turnover and other challenges at the MOH contributed to delays in initiating the process. With limited time remaining for before ZISSP ends, the MOH decided in 2013 to instead develop treatment flow charts and job aides (which are more summarized) for the mentors. These tools not only equip clinical mentors with important

[5] With the exception of Western Province.

job aides, but can also facilitate effective clinical case management by frontline health workers who do not have readily available mentors within their geographical reach.

In 2013, ZISSP facilitated two workshops where experts developed treatment flow charts and job aides for selected clinical conditions (internal medicine, surgery, pediatrics, obstetrics and gynecology, psychiatry, anesthesia, physiotherapy, ear nose and throat, oncology, nursing care and radiology). These tools were submitted to the MOH for ratification.

Training of Clinical Mentors: Following the formation of multi-disciplinary CCTs at provincial and district levels, mentoring has progressed very well. However, there has been a challenge of high attrition of the mentors through job transfers. In 2013, ZISSP trained 190 health workers (83 females, 84 males, and 23 unclassified) from Central, Eastern, Luapula, North-western, Southern and Western Provinces. This exceeded the target of 50 because there was a high mentor attrition rate and drop outs (in Luapula and North-Western provinces, where ZISSP has had no stable CCS filled position since 2011). Some funds were reprogrammed from ZISSP's budget for clinical mentoring.

Provincial CCT Technical Support Supervision to DCCTs: Nine[6] provincial CCTs provided TSS to all the district CCTs (DCCTs) in their respective provinces. In Copperbelt Province, a workshop was convened with all Clinical Care Officers (an extension of the CCS at the district level) to evaluate the clinical mentorship program.

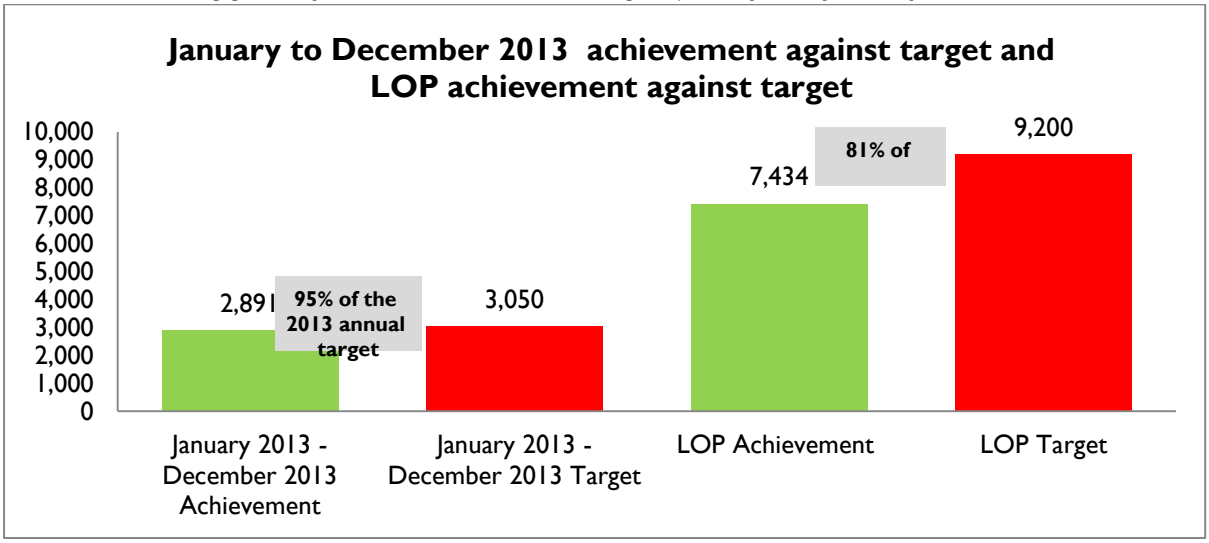
Mentorship Needs Identification Meetings: Since 2011, ZISSP has supported the CCTs to hold meetings to review health information data and other relevant reports to identify the mentoring needs in health facilities and of health workers. In 2013, ZISSP supported 28 DCCTs to hold these meetings. This appears to be a significant drop from the 107 meetings reported in 2012, but in fact the identification of mentoring needs was added as an agenda item at the 2013 district QI committee meetings. This shift has not changed the response to the health worker's mentorship needs.

Clinical Mentorship: Clinical mentorship of health workers is a strategy for quality improvement of health service delivery, especially for frontline health workers at primary health care levels. In 2013, ZISSP supported mentorship in specific support functional areas (pharmacy, laboratory, nursing care, counseling, etc.), in addition to mentorship in clinical conditions (ART, prevention of mother-to-child transmission, malaria, tuberculosis, management of labor, surgical operations, nutrition, IMCI, etc.). The addition of mentoring in these support functional areas is key for enhancing QI in health service delivery.

From January to December 2013, the CCT had conducted 2,891 mentorship sessions against a target of 3,050 representing 95% achievement. Cumulative from project inception, a total of 7,434 mentorship sessions have been done against the end of project target of 9,200 representing 81% (**Table 3**) Most of these health workers were mentored in the 50 selected model health facilities, five in each province.

[6] With the exception of Luapula (which had no ZISSP-seconded CCS for most of the year due to high attrition).

Table 3: Clinical mentorship sessions completed by the Clinical Care Teams with ZISSP support (2013 data and life of project (LOP) data)



Support to Clinical Meetings: Health facility-based clinical meetings provide a mechanism for continuous staff development and an opportunity to provide updates to health workers on current clinical case management protocols in various fields. Topics are identified based on the major causes of morbidity and mortality. In 2013, ZISSP supported the CCTs at provincial and district levels to conduct 73 clinical meetings in five provinces (Central, Lusaka, North-western, Southern and Western). Although clinical meetings are conducted in health facilities in all ten provinces, ZISSP only supported meetings in 73 health facilities in 2013, while the rest were supported by the MOH. The National ART Update Meeting is an important forum where updates are shared on the current trends in HIV prevention and case management. Participants in turn share the updates with the service providers in health facilities in the provinces. In 2013 only four CCSs attended the meeting. (The other four did not attend due to competing activities that were already scheduled).

Support to MOH 2014-16 Mid Term Planning Cycle: In 2013 the ZISSP team leader provided input to the MOH with priority identification of specific focus areas for 2014-16 related to QI and clinical mentorship. At the provincial level, the CCSs provided technical assistance to the adaptation of the national-level profile to their respective provincial profiles during planning launches and again provided district-level technical assistance in the use of health management information for planning. This support enhanced prioritization of poorly-performing health program indicators in their provincial and district 2013 work plans. The CCSs also facilitated the review of the district and hospital action plans to ensure adherence to the planning guidelines.

2.2 MANAGEMENT AND LEADERSHIP

In 2013, the focus continued with the work initiated in 2012. The main focus areas were:

1) Strengthening systems in planning and data management and usage.
2) Strengthening systems for performance monitoring and financial management.
3) Conducting capacity building programs to strengthen Provincial Health Offices (PHOs) using existing MOH training approaches and the Zambia Management and Leadership Academy (ZMLA) concept.

2.2.1 Strengthening systems in planning and data management and usage

Annual Planning: In 2013, ZISSP continued to provide support for the annual planning cycle. ZISSP support focused on the continuation of collaboration with the MOH on district-level planning processes and the smooth transition of DHOs to the MCDMCH. Working with both ministries ensured a coordinated process for undertaking the 2013 annual planning process and also provided a learning environment for MCDMCH. This effort resulted in a joint launch of the 2013 annual planning process by the two ministries. In 2014, ZISSP will continue to strengthen capacity of MCDMCH to take the lead in the overall health planning process.

To support 2013 planning, ZISSP provided technical and financial support to the two ministries to review 2012 their performance using the *Step-by-Step Guide to Planning*, developed by MOH with ZISSP support during the first quarter. Using the guide, program officers reviewed program performance, set priority health programs for the 2014-2016 Medium Term Expenditure Framework (MTEF), and drafted technical planning updates (which were presented during the national health planning launch held in June).

At provincial level, ZISSP assisted PHOs to hold two-day pre-planning launch meetings. A total of 195 participants (130 males, 65 females) attended these meetings against the planned 200. Provinces reviewed their performance for the previous year in key health interventions (such as malaria, HIV, maternal and child health, and nutrition) using HMIS indicators and provincial action plans. Using the 2012 Provincial Statistical Bulletins and the *Step-by-Step Guide to Planning*, PHOs adjusted the national updates to provincial-level performance in readiness for the launch in their districts and set priorities for the coming year.

For the first time, ZISSP provided technical and financial support for two-and-a-half day pre-planning meetings at district level to prepare for the annual planning process. During the district preparatory planning meetings, a total of 162 program officers (128 males, 34 females) were oriented to the *Step-by-Step Guide to Planning*. The target of orienting 135 people was exceeded as a result of including participants from the newly-created districts, especially in Western and Lusaka Provinces.

New innovations in the planning process were used in different provinces. For example, Luangwa and Chongwe Districts (which co-funded both the pre-planning and the review meetings) included hospital and health center staff from the onset. Holding combined meetings (as opposed to separate meetings as per the planning guidelines) assisted the districts to speed up the process of planning and reduced the cost of undertaking separate meetings for districts and health centers. This innovation also helps create interpersonal linkages and better understanding between levels of cadres and challenges they face, and enables sharing of lessons learned across levels.

District program officers appreciated the preparatory meeting process and guide as an improvement over the prior approach of using launch meetings. Preparatory meetings accelerated their planning process and adequately prepared them to guide the planning exercise with their health institutions. The Director of Planning and Information from MCDMCH also appreciated ZISSP's support to the districts, which he observed during

participation in the pre-planning meetings for Senanga, Kalabo, Lukulu, Shangombo and the Mulobezi Districts in Western Province (**Photo 11**). He mentioned that this also provided him an opportunity to understand the concept of bottom-up planning.

Photo 11: Simmy Chapula, the Director of the Department of Planning and Information at MCDMCH, participated in district-level planning in four districts. "This pre-planning exercise is very important because it sets a focus in the planning process. Other districts should be encouraged to come together and hold the pre-planning meeting so that when they go back it will be easier for them to develop their plans."

Photo 12: Mr. Kaliki, the Deputy Director of Monitoring and Evaluation at the MOH commended the ZISSP approach to planning, which was aligned with and supportive of the ministry's overall health programs and priorities, thereby avoiding fragmentation of efforts.

"From MOH, we really support this process and we want to ensure that programs that support information management processes continue and we urge all other stakeholders to support this effort."

Strengthening Management and Use of Data: In 2013, ZISSP provided technical and financial support to the MOH M&E Unit to develop and finalize Data Quality Audit (DQA) guidelines that will provide a standardized process for conducting DQAs at all levels. The process for finalization involved hiring a local consultant to assist the MOH. Following completion, ZISSP supported a TOT for 27 program officers (21 males, 6 females) from MOH and MCDMCH and supported their application of the concepts in the field. The TOTs will further roll out the tool to provinces in 2014 with ZISSP support. Both ministries hope that the guide, which is the first of its kind, will assist them to identify and address current weaknesses in data management.

2.2.2 Strengthening systems for performance monitoring and financial management

Performance Assessment: Following the 2012 support for the review, alignment and standardization of indicators in the performance assessment (PA) tools, ZISSP provided technical and financial support in 2013 for the orientation of program officers from PMOs on the revised tools. During 2013, a 22 program officers (15 males, 7 females) were oriented in financial management. Since project inception, a total of 208 program officers

(165 males, 43 males) from ten provinces had been oriented on these, exceeding the target of 150. A higher number of program officers were oriented due to the inclusion of officers from the newly-created districts. Participation of the ZISSP provincial Management Specialists (MS) in the PA preparatory meetings helped in identifying a number of issues arising from the use of the new tools, which was something requested by MOH in absence of a conducting a formal pilot of the use of the PA tools.

ZISSP co-funded the fourth quarter PA TWG meeting, chaired by the Directorate of TSS. The meeting was used as a preparatory meeting for provincial PA visits by the national MOH, which aims to improve capacity of PHOs and districts in problem analysis and definition, leading to realistic and evidence-based action plans developed by health institutions.

National Health Accounts: As part of strengthening MOH financial management policies, ZISSP provided financial and technical support to the MOH to finalize the National Health Accounts (NHA) report for 2007-2010 expenditure period. In July 2013, the Health Care Finance TWG served as a forum for a half-day consensus meeting for stakeholders that participated in the survey. During this meeting, the MOH disseminated preliminary findings from the NHA report. Comments were incorporated into the final report, which will be printed and distributed to stakeholders in 2014.

Responding to a change in focus by the MOH and MCDMCH, ZISSP also provided financial support to initiate preparations for the next NHA survey (covering 2011-2012). In November, ZISSP co-funded the orientation of the Zambian NHA team in the System of Health Accounts (SHA) 2011 methodology, which was facilitated by the WHO local office. A total of 44 officers (34 males, 10 females) from MOH and MCDMCH headquarters, provincial and hospital offices participated in the workshop. Following this training, the national NHA team has initiated preparations for the NHA survey, but did not produce questionnaires in time for the proposed data collection process originally scheduled for December. In addition, the MOH has submitted an official letter of request for technical assistance (TA) from ZISSP outlining the type of support required, which indicates that both Abt Associates and WHO will be expected to provide TA for next NHA exercise.

In 2013, ZISSP continued to support MOH to analyze the data collected through the proposed NHA institutionalization tool, which was piloted alongside the 2012 NHA survey. There were several lessons learned arising from this process.

- Although data collected through this tool was analyzed alongside the NHA data as part of collecting expenditure data at district level, it was suggested that these data be independently analyzed to measure the appropriateness of the tool for the purpose it was designed.
- Piloting of the institutionalization tool alongside NHA data collection was not effective at all levels, as the tools were collecting the almost the same information. The tool only performed well in institutions where there were no questionnaires for the NHA being administered (e.g., the District Health Management Teams).
- It is possible to institutionalize the NHA, provided tools for collecting data are developed in line with what NHA sub-account classifications require.
- Due to unclear expenditure tracking systems in the institutions visited, it was not possible to collect the required data through the proposed NHA institutionalization tool, especially for expenditure data outside the mandate of the health system.

- The questionnaire did not capture consistent information from non-governmental organizations (NGOs), employers, and pharmacies, resulting in the under-estimation of the total health expenditure at district level.
- The only consistent data that could be admitted for analysis came from four districts (Serenje, Mkushi, Kapiri Mposhi, Mumbwa). Data from these four districts were generalized to refer to the whole Central Province (in the absence of acceptable data from the remaining two districts (Kabwe and Chibombo)).

With these findings, the original resource tracking tool was adjusted in line with the NHA requirements (SHA11) and a full report has been drafted. A database has also been created which will enable individual districts to input data on a bi-annual basis, as suggested by the MOH and MCDMCH. The Ministries hope to place the tool at district level to track expenditure for community-level activities and at their health institutions to be used as part of the routine financial reporting system.

Financial Management Training and Desk Review: ZISSP supported training for 71 non-financial managers (54 males, 17 females) from eight districts of Copperbelt, Northern, Muchinga and Central Provinces[7]. The five-day course covered government financial management procedures, and included guest facilitation from the Drug Enforcement Commission and Anti-Corruption Commission on specific topics (e.g., corruption). ZISSP also supported a desk review to determine the extent to which this training package addressed identified weaknesses in financial management processes and produced the intended outcomes. The desk review was conducted in four target districts where non-financial trainings were held last year and looked at performance prior to and after trainings. Preliminary findings revealed that districts demonstrated improvements in compliance to approved government financial procedures post training. The draft report is currently in the process of finalization.

2.2.3 Conducting capacity building programs to strengthen PHOs using existing MOH training approaches and the ZMLA concept

Through the leadership of BRITE, ZISSP has continued the ZMLA program in 2013. Key 2013 ZMLA activities included the following:

Mid-Term Program Evaluation in August 2013: The ZMLA evaluation collected feedback on program performance after the first year of implementation from five provinces using focus group discussions and in-depth interviews with 36 key informants. Findings of the evaluation were presented and discussed in the ZMLA Program Review Meeting in September 2013 (**Figure 3**). Twenty-eight meeting participants (17 males, 11 females) reviewed the first edition ZMLA training modules for content, consistency in the layout, and delivery of material. Current mentorship activities and approaches were also reviewed. The recommendations arising from this meeting were incorporated during the production of the second edition of the training modules. (Trainers and mentors have since received orientation to the revised modules.) To ensure sustainability of ZMLA after ZISSP ends, meeting participants resolved that the project should ensure the full engagement of the government at national and implementation levels, with the National Institute for Public

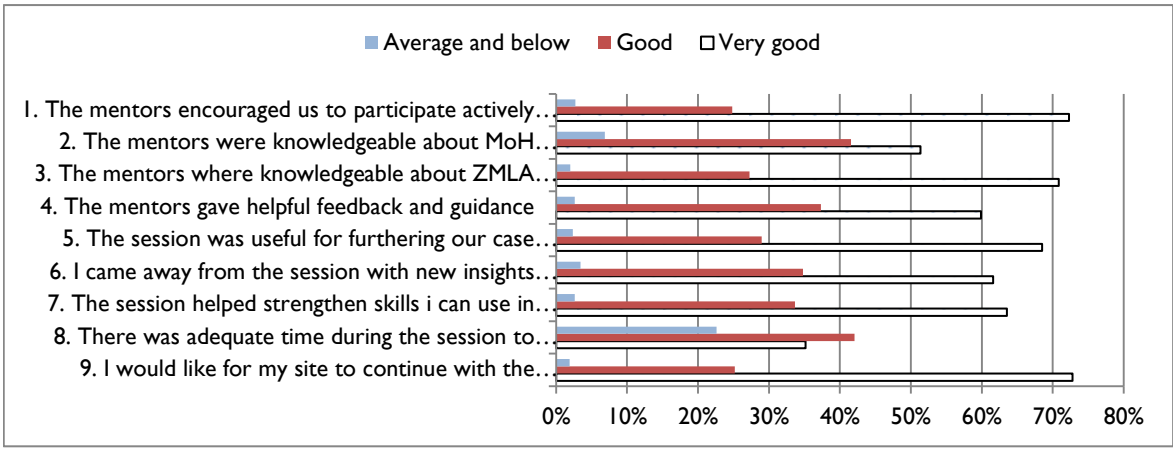
[7] The training reached participants from seven ZISSP target districts and one non ZISSP target district (Chinsali). Chinsali was included at the request of Muchinga PMO as the district is the new capital for Muchinga Province and has new management personnel.

Administration (NIPA) continuing to deliver ZMLA. Other identified mechanisms for ensuring sustainability of the ZMLA concept were to use the existing government processes to deliver mentorship sessions, such as the PA process. A full meeting report was produced by ZISSP, which includes more detail on the evaluation, discussion and recommendations.

Figure 3: An example of the ZMLA Mid-Term Evaluation findings (extracted from report)

One of the major findings from the survey revealed that 100% of respondents felt that they were adequately trained to meet their management and leadership responsibilities. The survey also looked at participants' perceptions with the mentorship sessions (n= 200 participants), which indicated that participants felt that mentoring sessions were very good.

Ratings of the four, two-day ZMLA mentorship sessions (n=200)



Graduation of the First ZMLA Training Cohort: The ZMLA graduation event (organized by NIPA, MOH, ZISSP and BRITE) was held at the NIPA main campus in the morning, while a press and media reception was held at the government complex in the evening (Photo 13). Higher diplomas were awarded to 177 trainees (123 males, 54 females). The remaining 190 participants did not meet all the diploma requirements and therefore received certificates of attendance. In the fourth quarter, ZISSP provided financial support to mentor 123 of the 190 certificate group and successfully enabled 95 to meet all the necessary requirements for higher diploma. Therefore, out of the first cohort of 367 trainees, a total of 272 (191 males, 81 females) will have completed the course with diplomas.

Photo 13: ZMLA graduates at the NIPA main campus, held on 27 September 2013. At the graduation, one of the graduates, Senior Chief Kanongesha of North-Western Province, gave an inspiring speech on how the ZMLA program has changed his way of managing community health problems. "This program has enabled me to be part of the Mwinilunga District planning activities for community health programs for the first time. I, therefore, urge district health teams to consider chiefs in their health programs."

Initiation of Second Phase of ZMLA Course: In 2013, ZMLA initiated recruitment of the targeted 198 trainees from 18 ZISSP target districts for the second phase of ZMLA training. To date, 118 participants (81 males, 37 females) have been recruited. At the request from the Muchinga PMO, the cohort includes participants from Chinsali District (a non-ZISSP target district) because of the district's new management responsibilities. In 2013, ZMLA provided training and mentorship in the first two modules to 118 participants (81 males, 37 females) from six of the nine cohorts (six provinces), with training for the remaining three provinces planned for January 2014. Graduation of the second cohort is anticipated for September 2014.

2.3 MALARIA

ZISSP malaria activities have three focus areas:

1) Support for the Indoor Residual Spraying (IRS) program in 20 target districts.
2) Malaria case management, with particular emphasis on children under five years and pregnant women.
3) Active case surveillance in Lusaka District.

2.3.1 Indoor Residual Spraying (IRS)

Needs Assessment: With technical and financial support from ZISSP, the National Malaria Control Centre (NMCC) completed a needs assessment in 2013 with the following specific objectives:

- To provide technical guidance by assisting current IRS implementing districts to plan IRS scale up.
- To conduct a physical check on the suitability of storage facilities in the districts.
- To assess the suitability of wash bays and soak pits in the districts and provide technical guidance in ensuring that they meet minimum standards.
- To ensure that districts have planned adequately in terms of insecticides, personal protective equipment (PPE), and pumps in relation to scale up of activities.
- To ensure that the districts are aware of the need to take environmental compliance issues into consideration prior to start of the spray season.

The assessment results formed the basis for the quantification of annual requirements for IRS commodities in 20 Presidential Malaria Initiative (PMI)-supported districts, determined the district readiness for the next spray season, and looked at changes that occurred since the previous spray campaign. The needs assessments also served as a capacity-building exercise with district and provincial staff.

Training in Indoor Residual Spraying: With ZISSP support, NMCC and MCDMCH trained 63 Environmental Health Technicians (EHTs) from Eastern, Muchinga and Northern Provinces as IRS TOTs This training was also used as a trial for the newly-drafted IRS training modules. The lowest average score in the pre-test was 43% whereas the highest average score was 88%. The average score was 65%. The post course test showed a significant improvement, with the average score of 76% (range was 53% to 96%). There was an improvement in performance in the post-test over the previous year. Following the TOT workshop, the TOTs cascaded trainings for community volunteers as spray operators. (Spray operators are the people who do the actual spraying of the structures). The cascades took 18 days; three days for theory and 15 days to master the spraying technique (although

this duration is under consideration for reduction). Each district conducted its own cascade training.

Training in Disease Data Management System: As Zambia continues to implement and scale up its malaria control program, it is critical that programmatic, monitoring, and surveillance data be managed in such a way to allow informed decisions to be made. The Disease Data Management System (DDMS) tool, developed by the Liverpool School of Tropical Medicine (LSTM), supports the decision-making process that will enable national vector-borne disease control programs to monitor progress and identify issues in real time, so that limited resources can be used intelligently and efficiently to solve problems. At the central level, ZISSP provided financial support in 2013 to conduct two orientations for: 1) six NMCC and ZISSP entomologists and technicians (4 males, 2 females) on how to use the tool for entomology purposes, and 2) eight NMCC and ZISSP staff (7 males, 1 female) on how to use the tool for IRS tracking and reporting. At district level, ZISSP provided financial and technical support to orient data entry assistants on how to capture spray data from spray operator forms and enter into the DDMS. Other IRS staff received an orientation in the DDMS as part of the Data Entry Assistants orientation. The total number oriented in the districts is shown in **Table 4**.

Table 4: Number of persons trained in DDMS with ZISSP support (2013), by cadre

Category of Staff	Males	Females	Total
Data Entry Assistants	14	6	20
IRS Managers	18	1	19
Master Trainers	3	0	3
Consultants	3	0	3
Chief Environmental Health Officers	1	1	2
Total	**39**	**8**	**47**

Monitoring and Supervision of IRS Activities: Three monitoring and supervision exercises (comprised of staff from NMCC, ZISSP, PHOs and DHOs) were conducted during the IRS implementation phase: one at the beginning of the spraying phase; one in the middle; and one towards the end of spraying. The main objective of the monitoring and supervision exercise was to provide technical support to the districts to assure that the spraying of housing units/structures was conducted according to IRS guidelines. Supervision has been cited as one of the major challenges during the implementation period, and strategies to improve monitoring and supervision have been employed (which involve 'beefing up' the monitoring teams). In order to further improve monitoring and supervision, each of the 20 districts were provided with one master trainer to help in the supervision and provide technical assistance to the spray teams whenever necessary. At provincial level, three IRS coordinators were contracted during the implementation period to provide added technical support to district teams. Feedback from the field indicated that monitoring and supervision needs to be strengthened, with a better strategy identified, so that provinces and districts can be best assisted to strengthen their supervision capabilities.

Distribution of IRS Insecticide and PPE Training in Indoor Residual Spraying: To ensure that the right IRS commodities are available at the right time and in the right quantities, ZISSP has been mandated to distribute IRS commodities procured by PMI to all 20 PMI-supported districts. Between July and August, ZISSP supported NMCC in distributing insecticides and PPE to all the 20 PMI supported districts in readiness for the

2013 spray campaign. All the insecticides received at central level were stored at Medical Stores Limited (MSL) while the PPEs were stored at NMCC before being distributed to the districts.

Disposal of Empty Insecticide Bottles: ZISSP draws the support of the African Indoor Residual Spraying (AIRS) project in the area of environmental compliance. Approximately 78,000 empty Actellic plastic bottles generated in the 2011 and 2012 IRS campaigns were collected from the district warehouses and transported to the Lusaka IRS Center where the sorting and cleaning were done. The polyethylene terephthalate and high density polyethylene bottles were sorted out from their corks and labels so as to prepare them for crushing according to the colors and bottle types. Currently the bottles are being kept at the Lusaka IRS Center before they can be shredded into flakes by a local company.

At the moment Zambia has no recycling facilities that can process the empty plastic bottles into non-consumptive products. Therefore using the local company in Zambia, the empty plastic bottles will be shredded into flakes and baled so that this material can then be transported to a PMI country where recycling facilities exists[8]. The idea of shredding the material locally is to reduce on the total volume occupied by empty bottles, thus reducing transportation costs to the recycling country.

Geocoding Training and Enumeration: ZISSP trained 110 enumerators (52 males, 58 females) to carry out geocoding in four districts and trained 21 supervisors to assist with supervision. Details of the numbers trained and the structures enumerated are shown in **Table 5**.

Table 5: Number of geocoders trained by ZISSP (2013), by district and gender

District	Enumerators Trained	Male	Female	Supervisors Trained	Structures Enumerated
Mungwi	20	5	15	5	13,378
Isoka	30	15	15	5	24,376
Nakonde	30	16	14	6	26,432
Chadiza	30	16	14	5	Still going on

The exercise was successfully carried out with the use of community volunteers. The electronic questionnaires were used to collect additional attribute data on previous activities related to the distribution of insecticide-treated nets (ITNs) as well as IRS activities. The geographical positions were measured using a Global Positioning System (GPS) antenna embedded on the personal digital assistants (PDAs). The enumerated locations were plotted on a topographical map background. It is hoped that complimentary methods will be used in 2014 to update districts which were previously enumerated.

IRS Data Audit: In 2013, ZISSP supported NMCC to conduct an IRS data audit in Eastern, Muchinga, and Northern Provinces in the PMI/ZISSP-supported districts to ensure adherence to data quality. The activity looked at IRS data management, particularly how IRS documents are filed. The exercise also involved verifying data accuracy by randomly picking IRS Spray Operator Daily Forms for any day or month, comparing the spray operator form

[8] Shredded plastics can then be processed into non-consumptive products such as air vents, fence poles, electric wire fence insulators, pavement blocks, plastic chairs and plastic ceiling cards.

with the IRS Supervisor Form and the IRS Daily Coordinator Form, and comparing the data to the spreadsheet that was sent to NMCC. Katete District had strong performance in record-keeping (i.e., orderly filing) and accurate data aggregation, which indicated strict supervision structures. Mambwe, Mpika, and Isoka districts also did well. In two other districts, the office was unable to trace the hard copy data collection forms for specific days for the team to check against the consolidated national-level data. In other cases, there were mathematical mistakes resulting in either under-reporting or over-reporting. The data audits indicated that more emphasis is required on district-level supervision to enable and maintain quality reporting. The activity was a good reminder to districts to ensure that data were kept orderly and verified before final submission. The districts were advised on areas needing improvement to assure data quality.

Entomology Investigation for Insecticide Resistance: The 2011 entomological insecticide resistance monitoring, mosquito bionomics studies and species mapping in 20 districts identified that *Anopheles funestus* is wide spread as the main vector in Zambia. In North-western Province, results demonstrated that the *An. funestus* population exhibited varying susceptibility to carbamates with a mortality range of 95.1% and 100%. However, this population was highly resistant to the pyrethroids deltamethrin and lambda-cyhalothrin with mortality ranging between 64.7%–91.6% and 40.7%-64.3% respectively. The organophosphate, pirimiphos-methyl, was the only insecticide that achieved 100% mortality and appears to be the most viable insecticide for the province.

Figures 4 and 5 (below) provide further information on the vector distribution and insecticide resistance in Zambia in 2013. To maximize the impact of IRS, ZISSP initiated support for NMCC entomology teams in November 2013 to determine the quality of IRS operations and the residual decay rate of insecticide sprayed through the cone bioassay tests in three sentinel sites (Katete, Kasama and Isoka). This activity will continue until the efficacy drops below 80%.

Figure 4: Malaria vector distribution map (2013), Zambia

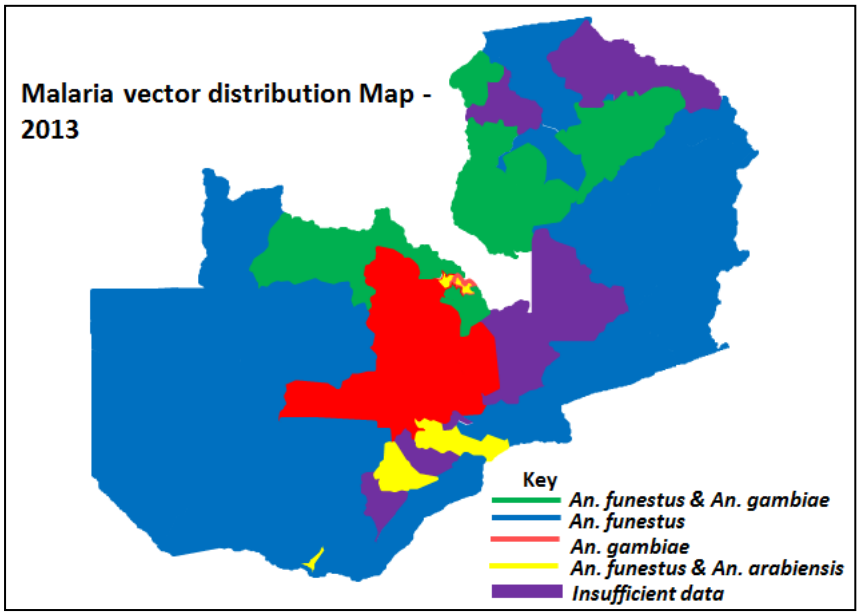
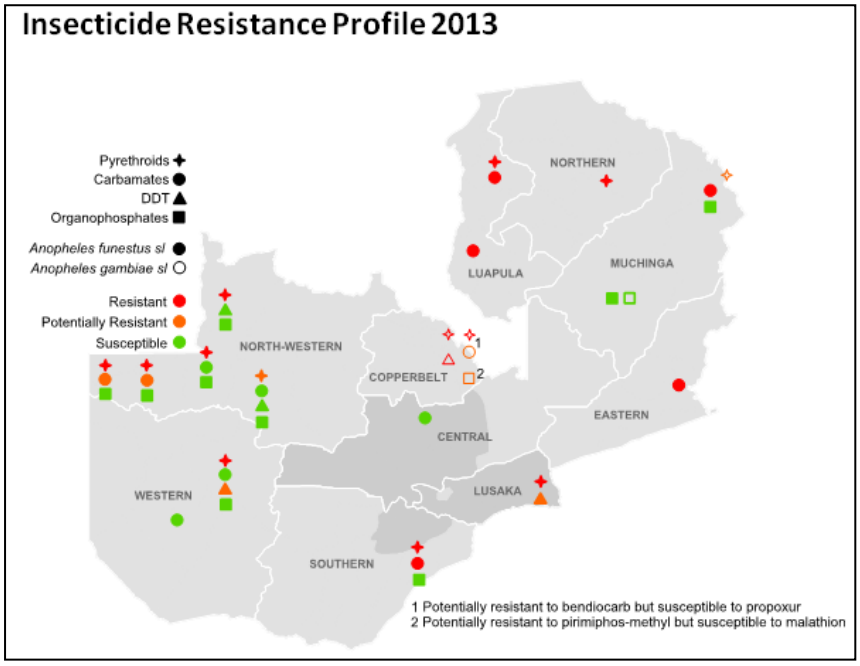


Figure 5: Insecticide Resistance Profile (2013), Zambia



Entomological Surveillance: Following the establishment of the Insecticide Resistance Management TWG (IRM TWG) in 2010, procurement of insecticides for IRS has been more contingent on local insecticide resistance data. Because insecticide resistance changes with time and space, it was essential that resistance surveillance be expanded since the complex nature of resistance distribution requires a more granular and timely approach.

Therefore, to ensure timely updates on insecticide resistance data over a vast area across the country, ZISSP together with Akros provided support for capacity building in basic entomological surveillance for 24 EHTs (19 males, 5 females) from nine PMI-supported IRS districts **(Figure 6).** The training comprised modular sessions of both theory and field-based practicums, which allow EHTs to experience hands-on field exposure before implementation in their own catchment areas. The 2013 training brings the total number of trained EHTs from inception to 80 (63 males, 17 females,) from 29 districts.

Figure 6: EHTs trained in entomological surveillance (Zambia), 2012-2013

Following the successful baseline entomological surveillance trainings, on-site feasibility assessments, distribution of entomological surveillance tool kits, and reorientation of EHTs and CHWs in nine new districts sentinel sites, ZISSP (with Akros Global Health) supported NMCC to conduct monthly integrated entomological surveillance sessions in nine additional districts. These were: Chadiza and Lundazi (Eastern Province); Chinsali and Isoka (Muchinga Province); and Chilubi, Luwingu, Kaputa, Mporokoso and Mungwi (Northern Province). The nine new sites, alongside the four previous sites (Ndola, Chipata, Mongu and Kafue) have since started sending their monthly specimen collections to NMCC for post-district analysis and quality assurance. In order to accelerate integration and enhance sustainability of the surveillance program into integrated district annual action plans, the MOH asked all PHOs and DHOs to introduce and plan for entomological activities starting with the 2013/2014 planning cycle. All sites have since confirmed inclusion of and planning for entomological annual activities for 2014 and beyond.

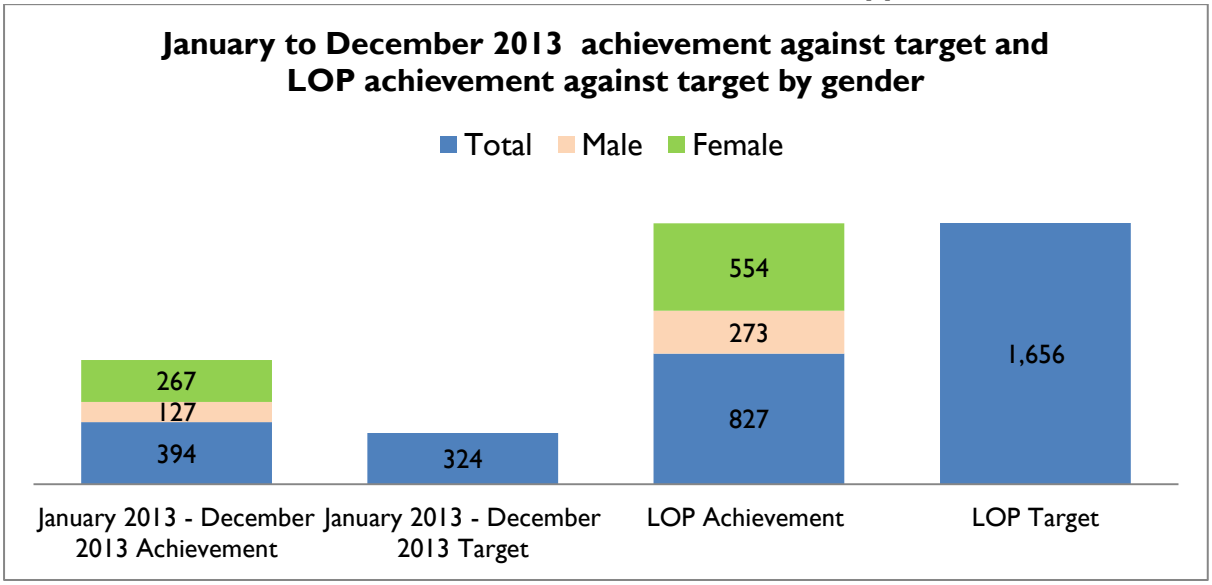
An ACCESS database has been created to facilitate capture of mosquito species/genus and vector densities at facility/district level. This will allow periodic transmission of aggregated data by EHTs from the districts to the NMCC so that policymakers at NMCC can view vector indicators and subsequently formulate effective strategies and interventions. For post-district specimen analysis and quality assurance, NMCC and ZISSP put together a team of technical staff to assess and analyze specimens from the field for purposes of validation, quality control/assurance and provision of feedback to EHTs at field level.

Maintenance of the National Entomology Laboratory and Insectary: ZISSP provided technical and logistical support to the NMCC to maintain a breeding mosquito colony for entomological monitoring, including paying monthly wages for one insectary technician and procuring daily routine commodities (such as washing detergents and sugar). The purpose of the insectary is to provide a source of mosquitoes of known genetic traits and to use these mosquitoes in monitoring the quality of spraying, the efficacy of insecticides on walls, and vector resistance. Plans to have a pre-fabricated insectary installed at NMCC have advanced. The tender for the expression of interest for the insectary has been done, and the evaluation of the tender is in process. The insectary will include necessary equipment and sufficient supplies for transition to a follow-on partner.

2.3.2 Malaria Case Management

Malaria in Pregnancy Assessment: From January to December 2013, ZISSP provided financial and technical support to the MCDMCH to conduct nine trainings in Focused Antenatal Care (FANC) for 394 health providers (doctors, clinical officers, midwives and nurses)(127males, 267 females) in seven provinces against a target of 324 (**Table 6**). Since project inception, ZISSP has trained 827 health care providers in FANC (273 males, 554 females).

Table 6: Number of health workers trained with ZISSP support in FANC

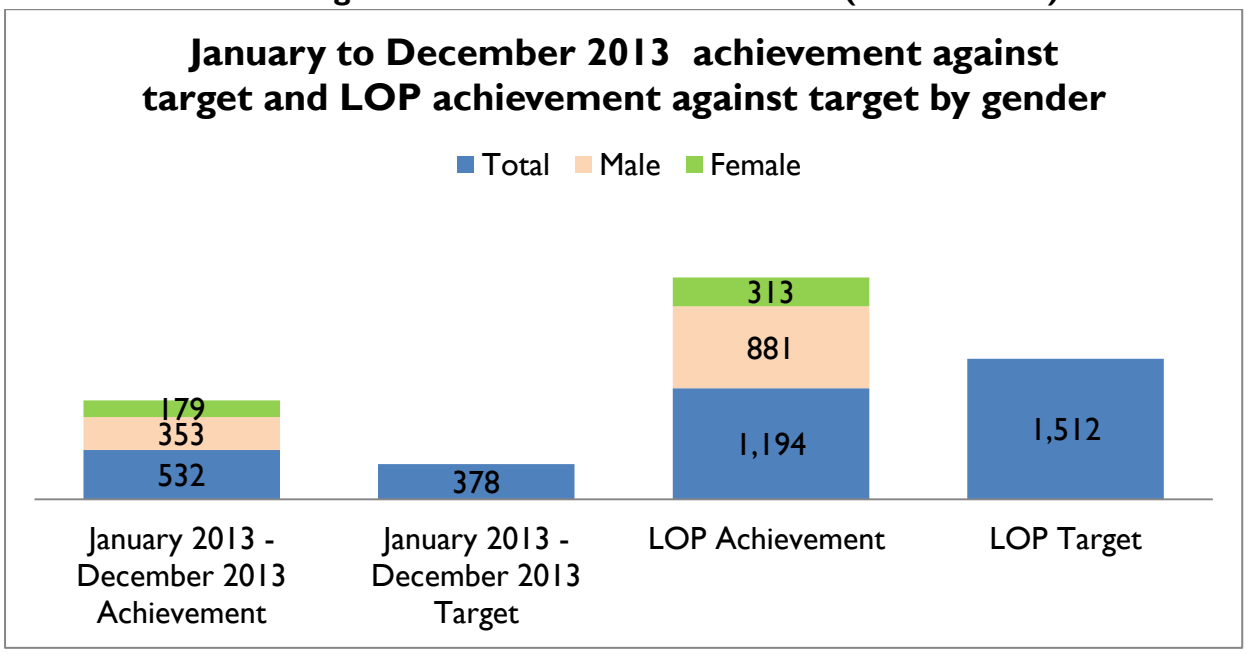


The training equipped health workers with the knowledge and ability to critically analyze and make decisions about clinical antenatal cases. Trainings were based on adult learning methodologies using interactive approaches to engage participants. The pre- and post-test average scores showed that participants' knowledge increased as a result of the training (**Figure 7**).

Training of CHVs and Facility Supervisors in Community Case Management: In 2013, ZISSP supported MCDMCH to train 532 CHVs, including some CHWs, (353 males, 179 females) and 64 facility supervisors (42 males, 22 females) from six districts in integrated Community Case Management (iCCM) (**Table 7**). The training targeted CHWs[9] and other CHVs who had not previously undergone the iCCM intervention training. CHWs learned to identify signs of common childhood illness, to test children with fever for malaria and to identify malnutrition. The training also transferred skills to CHWs on how to give basic treatment (ORS solution and zinc for diarrhea; antimalarial medicine for children with fever and who test positive for malaria; and/or an antibiotic for children with cough or difficult breathing). The training equipped supervisors with the knowledge and skills in iCCM for effective supervision and provision of support to the trained CHWs.

[9] In this case, the CHWs targeted with iCCM training were those who had received the six-week CHW training package.

Table 7: Number and gender of CHWs trained in iCCM (2013 - ZISSP)



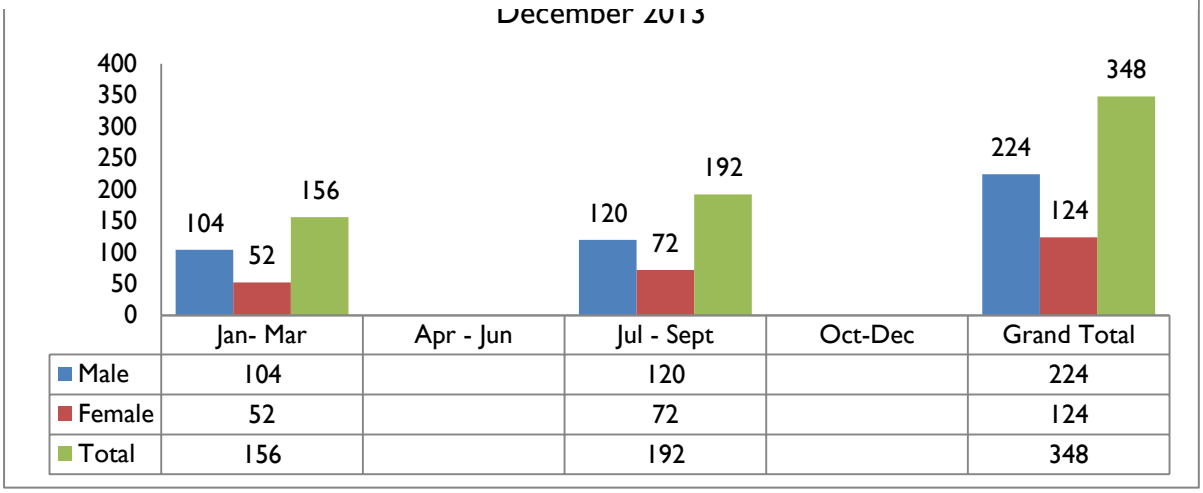
Training of Health Workers in Malaria Case Management Guidelines: With ZISSP support, the MOH and NMCC trained 348 health workers (224 males, 124 females) from five provinces on the malaria case management guidelines (**Table 8**). These trainings used participatory learning methodologies suitable for adult learning.

The following two areas were given particular attention:

- Management of malaria as malaria and not the treatment of fevers as malaria (improved treatment compliance)
- Ensuring availability of malaria commodities (rapid diagnostic tests [RDT]), microscopy reagents and antimalarial medicines) in all service delivery points through collaboration with all health workers at both district and health facility levels (e.g., ensuring facility reports are complete and submitted to the district; ensuring that districts receive and process facility forms).

Pre-post scores indicated that knowledge increased, with provincial averages of pre-test scores ranging from 58-68% improving to a range of 87-92% at the post-test.

Table 8: Number of health workers trained in malaria case management (Jan. to Dec. 2013), ZISSP



	Jan- Mar	Apr - Jun	Jul - Sept	Oct-Dec	Grand Total
Male	104		120		224
Female	52		72		124
Total	156		192		348

Technical Support Supervision: ZISSP provided support to district Clinical Care Teams to follow up participants trained in malaria case management, FANC and iCCM. The visits served as opportunities to provide on-site technical support to enhance the newly acquired skills. In particular, 19 female health providers trained in FANC from Luanshya and Lufwanyama received on-site mentorship. The follow-up activities ascertained the implementation levels and bottlenecks met during the first six months of implementation post training.

Challenges faced by health workers trained in FANC included inadequate space for dedicated and/or private ANC services; an inconsistent laboratory supply of reagents (Hb, RPR, urinalysis, pregnancy calculators, etc.); lack of stable transport for transportation of samples to the nearest laboratory; and under-staffed facilities.

Challenges noted during visits to CHWs trained in iCCM included an inconsistent supply of iCCM commodities (e.g., drugs, RDTs, ARI timers, sick child recording forms, mid-upper arm circumference [MUAC] tape); lack of transport (bicycles) to conduct follow-up visits and to facilitate clinic referrals; and lack of supervision in certain facilities due to understaffing.

2.3.3 Active Infection Defection (AID)

Lusaka District Community Medical Office (DCMO), with the help of Akros, ZISSP and the NMCC, has been implementing a focalized reactive case detection program for malaria in the district. Having piloted the program in five health facilities through 2011, the program is now fully running in 23 of the 28 health facilities in the district. The DCMO included this activity for five clinics as part of their 2012 action plan, and subsequently incorporated another five health facilities in 2013. A table in **Annex 1** summarizes the malaria situation by clinic for the year 2013.

In 2014, the district intends to take over the running of the Active Infection Detection (AID) program (also termed Step 3) in the district by including the 23 health facilities in their 2014 action plan. In preparation for this transition, the district's environmental health team conducted trainings in April 2013 for additional health facility staff (including EHTs and CHWs) in order to increase the number of health facility staff familiar with this program.

In addition, the NMCC (with support from ZISSP and Akros) introduced the malaria rapid reporting system, District Health Information System (DHIS2), in Lusaka District. The online system requires health facilities to report on 17 malaria-related indicators on a weekly basis, allowing for more regular monitoring of malaria data at health facility level in a timely fashion. With this system now running in Lusaka, the monthly data collection exercise, initiated as part of the surveillance system, may no longer be necessary. Discussion with NMCC suggests that the monthly exercise may transition to a quarterly visit to selected health facilities in the districts based data collected through DHIS2.

The expansion of Step 3 activities to the rural district of Mumbwa was initiated in August 2013, with over 200 CHWs trained in malaria testing and treatment. Going forward, these CHWs will start to send reports via mobile phone to the DHIS2. The system will increase the number of reporting units within the district from 35 to more than 200. This means there will be more granular data received from within each clinic catchment area, allowing easier and more focused targeting of interventions.

2.3.4 Additional National-level Malaria Support

Support to Technical Working Groups: ZISSP continued to support NMCC through three TWGs that provide technical guidance to the National Malaria Control Program (NMCP).

- IRS TWG: The IRS TWG met quarterly at the NMCC to follow up on IRS activities and provide technical guidelines on various IRS activities. In addition, the TWG compiled information required for the review of the National Malaria Strategic Plan (NMSP) 2011-2015 and discussed the on-going preparations for the 2013 spray campaign.
- IRM TWG: The IRM TWG met in Lusaka in July to receive updates from various stakeholders on their activities. In addition, the newly introduced National Health Research Bill, whose objective is to provide a framework for development, regulation, financing and coordination of health research involving human participants, was explained to the stakeholders. The technical advisory committee met soon after the IRM TWG to discuss the level of insecticide resistance in the country, suggesting the need for rotation of insecticides in order to manage pyrethroid susceptibility emerging in some parts of the country.
- Malaria Case Management TWG: The Malaria Case Management TWG met during the year to discuss updating the 2010 malaria diagnosis and treatment guidelines. The working group also met to compile information needed for the review of the NMSP 2011-2015. One recommendation coming from the group is the use of injectable Artesunate as an alternative treatment of choice in severe malaria.

Mid-term Review of the NMSP: The mid-term review of the NMSP 2011-2015 assessed progress in the two-and-a-half year period (2011-2013) of NMSP 2011-2015 implementation and identified recommendations for better performance and impact. With ZISSP technical and financial support, the IRS and Malaria Case Management TWGs conducted a rapid analysis of the Strengths, Weaknesses, Opportunities, and Threats (SWOT) of the plan. Based on the performance of the NMSP 2011-2015, the TWGs recommended improvements to strategies and objectives and developed key activities for the proposed extension of the NMSP 2011-2015 to 2016.

III. Task Three: Improve Community Involvement

3.1.1 Support to Neighborhood Health Committees

In 2013, the community team continued collaboration with and provided technical and financial support to the MOH and MCDMCH in strengthening capacities of community groups and establishing health systems that facilitated community involvement and engagement in health care service delivery. Activities included development of training materials, namely the *Facilitators Manual for Simplified Guide for Community Planning* and the *Participants Manual for Simplified Guide for Community Planning*. ZISSP supported trainings for 1,865 members (1,283 males, 582 females) of the Neighborhood Health Committees (NHCs) in health planning. The trained NHC members were affiliated with 78 rural health centers. The capacity building process provided an opportunity for NHC members to be updated with working knowledge in the five ZISSP focus areas to support the planning and implementation of community activities. Health care providers in the target districts increased their knowledge and improved their skills in key areas of health service delivery that helped them improve their involvement in providing support to NHCs.

The Community Health Coordinators (CHC) provided TSS to health center staff and NHC members. CHCs conducted quarterly support supervision visits to 93 NHCs to review the implementation status of community health-related activities, exceeding the annual target of 54 NHCs by 72%.

3.1.2 Safe Motherhood Action Groups

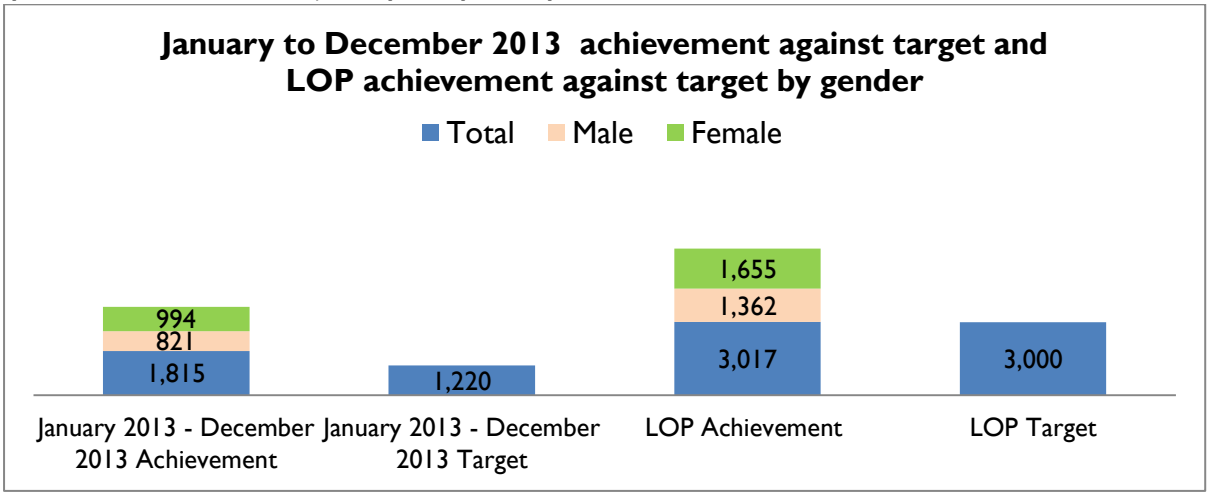
Training: ZISSP continued to provide support to the MOH and MCDMCH to strengthen Safe Motherhood Action Group (SMAG) operations in the 17 target districts, fully integrating the concept of Home Based Life Saving Skills (HBLSS) into the training content. Adaptation of the HBLSS training manuals is in process, and ACNM will support printing 2000 copies of the adapted training manuals for SMAGs in 2014.

In 2013, ZISSP trained 47 SMAG trainers (17 males, 30 females) from 36 health facilities across nine district health offices[10], including the PHO from Copper Belt. The training was held in Livingstone with support from ACNM.

During 2013, a total of 1,815 SMAG members (821 males, 994 females) were trained with support from ZISSP. Since project inception, ZISSP has supported the training of 3,017 SMAG members (1,362 males, 1,655 females) in 17 districts against the life of project target of 3,000 (**Table 9**).

[10] Nine districts by province: Copperbelt (Lufwanyama), Western (Shangombo), Central (Serenje and Mambwe districts), Northern (Mbala), Northwestern (Mwinilunga), Southern (Sinazongwe), Luapula (Nchelenge), and Lusaka (Chongwe).

Table 9: Number of SMAG members trained with ZISSP support by gender (2013 and Life of Project (LOP) data)



Procurement of Materials: In 2013, ZISSP procured T- shirts, bags, vests and umbrellas to support the work of 800 SMAG members. Other critical materials (such as gum boots, raincoats, bicycles and megaphones) could not be procured in 2013 due to inadequate funds.

Technical Support: The Community Health Team, in conjunction with ACNM and with support from master trainers, conducted Phase 2 post-training follow-up visits to SMAGs and 24 health facilities in Lukulu, Luangwa, Luanshya, Mwinilunga, Mpika and Serenje districts. The team conducted another post-training follow up in Phase 3 districts to 23 health facilities in Sinazongwe, Shangombo, Nchelenge, Mbala, Lufwanyama and Serenje districts.

During these follow-up visits, the Community Health Team reviewed the work of SMAGs and assessed their training and experiences in the HBLSS and SMAG approaches. The teams also took the opportunity to review service statistics, ascertaining the level of change before and after introducing and/or strengthening the SMAG's skills. Findings show that the mother and baby registers were in use and health facility staff had been making efforts to provide technical support to SMAGs. Capturing data coming from the health centers to the district and provincial levels continued to be a challenge.

In consultation with MCDMCH, ZISSP developed data management tools for SMAGs that are being used at health center, district, province and national levels to enhance monitoring and evaluation of the SMAG program.

Photo 14: SMAGs doing a role play at a community meeting at Lumsambwa Zone – Muchinka Rural Health Center in Serenje.

3.1.3 Small Grants

Funds Disbursement: In 2013, ZISSP disbursed K2,289,639.89 to grantees for various activities including training of SMAGs; training of CHVs as positive living advocates; engaging communities in annual health planning; providing RDTs and case management of malaria; and supporting community-based FP services. Grantees conducted behavior change communication (BCC) activities for preventive and health-seeking behaviors related to HIV, malaria, FP, child health and nutrition. Grants also supported the procurement of materials (such as bicycles, T-shirts and chitenges) to support the work of CHVs.

To date, the program has disbursed K3,449,448.16 to ten grant recipient organizations (**Figure 8**). This amount represents 86% of KR4, 027,794.13, which is targeted to be disbursed during the period from the August 1 2012 to March 30 2014 granting season.

Figure 7*:* List of ZISSP grantees (first and second cycle)

First cycle grantees:

1. Childfund Zambia*
2. Centre for Infectious Disease Research in Zambia (CIDRZ)
3. Kalomo Mumuni Center*
4. Thandizani Community Based HIV/AIDS Care and Support*
5. Community Integrated Health Education Program*
6. Groups Focused Consultations
7. Keepers Zambia Foundation
8. Diocese of Mpika Home Based Care Program*
9. Serenje Pastors Fellowship
10. Network of Zambian People Living with HIV/AIDS, Mwinilunga District Chapter

Selected for cost extension grants

Second cycle grantees:

1. Global Esthetes Mine
2. Rising Fountains Development Program
3. Development Organization for People Empowerment
4. Luangwa Child Development Program
5. Community Health Restoration Program
6. Groups Focused Consultations
7. Network of Zambian People Living with HIV/AIDS, Kalomo District Chapter
8. Adolescent Reproductive Health Advocates

Cost Extension Grants for First-Cycle Grantees: Following the successful implementation of some of the first cycle grants, ZISSP in collaboration with the MOH and MCDMCH requested proposals from first-cycle grantees for cost extension grants. ZISSP and the two Ministries used a full and open competitive evaluation process to evaluate the proposals. Of the eight organizations that expressed interest, five passed the selection criteria. The selected organizations have implemented their activities successfully in line with Abt/ZISSP standard guidelines, including cost principles, procurement procedures, financial and programmatic reporting and other mandatory standard provisions. In early 2014 ZISSP will finalize award documents and disburse funds to the selected grantees.

Grants Management Training and Organizational Capacity-Building for Second-cycle Grantees: ZISSP trained 25 representatives (18 males, 7 females) from eight new grantees in grants management. (These are the organizations that were recommended in the first cycle, but could not be funded due to inadequate funds.) The training provided information and skills to enable them to implement their activities in line with Abt/ZISSP standard

guidelines, including cost principles, procurement procedures, financial and programmatic reporting and other mandatory standard provisions. Funds disbursement will occur in 2014.

Provincial and District Grants Support Teams (GSTs) also conducted field visits to the grantees to be funded in the second cycle. The purpose was to revise proposals in order to facilitate the process of finalizing the scope of work for grantees by the national GST. A total of eight proposals were revised and subjected to an organizational capacity assessment to identify capacity needs. Capacity gaps identified were: financial management; monitoring, evaluation and reporting; resource mobilization and sustainability; governance; and management systems. To address these capacity gaps, ZISSP trained 23 representatives (14 males, 9 females) from grantees in organizational capacity building.

Technical Support Supervision to Grantees: ZISSP monitored grantees' progress in accomplishing planned activities within the approved budget and tracked grantee's achievement of the objectives set out in their proposals. ZISSP also provided technical assistance to grantees to ensure they are performing according to the planned milestones and activities and monitored whether activities were meeting adequate technical standards.

The following highlights arose from supervisory visits by ZISSP to grantees in 2013:

- Most grantees were on course in their activity implementation, as they had implemented most of their work plan activities.
- Grantees are working within existing structures, such as NHCs and with traditional leadership. This has promoted community involvement and ownership as traditional leaders see the projects as their own, and not as a foreign concept. A good example is Makumbi Rural Health Center in Mpika District where community volunteers, in collaboration with traditional leaders, have ensured that each household has a proper toilet, bathroom, rubbish pit and clean surroundings. This initiative has reduced incidences of malaria and diarrheal diseases.
- Grantees have come up with strategies to create and strengthen linkages with government and umbrella organizations. Groups Focused Consultations (GFC) started the process of linking their Youth Friendly Corners to the Ministry of Youth and Sport for sustainability purposes. At Mabumba Rural Health Center in Mansa, GFC facilitated the registration of the youth group (a requirement for affiliation with the Ministry of Youth and Sport). Once affiliated, the youth group will be eligible for to receive support, including financial assistance, from the Ministry. The Mpika Home Based Care Program has partnered with the Churches Health Association of Zambia (CHAZ) for a continuous supply of RDTs.
- Most grantees had weak M&E and financial management systems, and a few of them did not regularly submit activity reports. ZISSP provided capacity-building in these areas and will follow-up to ensure that their performance is improved.
- SMAG reports reflect an increase in institutional deliveries. At Chifusa Rural Health Center in Kalomo District, the number of institutional deliveries increased by 53 in the month of August from a monthly average of 15 deliveries. The increase in institutional deliveries, however, has also brought about other challenges such as demand for larger labor wards and more health center staff.
- There is an improvement in male involvement in maternal health. At Nameto Health Center in Kalomo District, most pregnant women were accompanied by their male partners for HIV testing and other safe motherhood activities.

- The availability of bicycles has improved the mobility of caregivers, which has in turn increased access to community health care. In Mpika District, malaria agents were able to reach far-flung areas (including fishing camps) for RDT and malaria case management. In Mwinilunga District, support group members were using bicycles to collect drugs from the district health office whenever there were delays in mobile ART.
- Grantee activities are encouraging other organizations to participate in health promotion activities in the communities. In Sailunga Chiefdom in Mwinilunga District, the local chapter of the National Association of People Living with HIV (NZP+) established support groups and prompted World Vision Zambia to introduce mobile ART services in the area. The formation of the support groups by Mwinilunga NZP+ has also shown the following benefits: (a) more people living with HIV have publicly disclosed their status, which can positively contribute to reducing HIV associated stigma in the communities; (b) support group members have facilitated the establishment of income generation activities, such as gardening and raising goats, which improve their nutritional status; (c) support group members have shown increased support for one another in ART adherence.

Close-Out Process for First-Cycle Grantees: To date, ZISSP has supported ten organizations through the Grants Program. The grantees are expected to close out their grants during the period October 2013 to March 2014. In preparation, ZISSP conducted a close-out orientation meeting for grantees to provide guidelines on the close-out process to ensure smooth closure of grants. A total of 24 participants (6 females, 18 males) from nine organizations attended the meeting. (The 10th organization, Serenje Pastors fellowship, was not represented as ZISSP did not renew their contract due to their financial mismanagement.) Following the meeting, a consultant conducted close-out field visits to nine grantees to ensure that close-out processes and financial obligations were met on the part of ZISSP and the grantees.

3.1.4 Behavior Change Communication

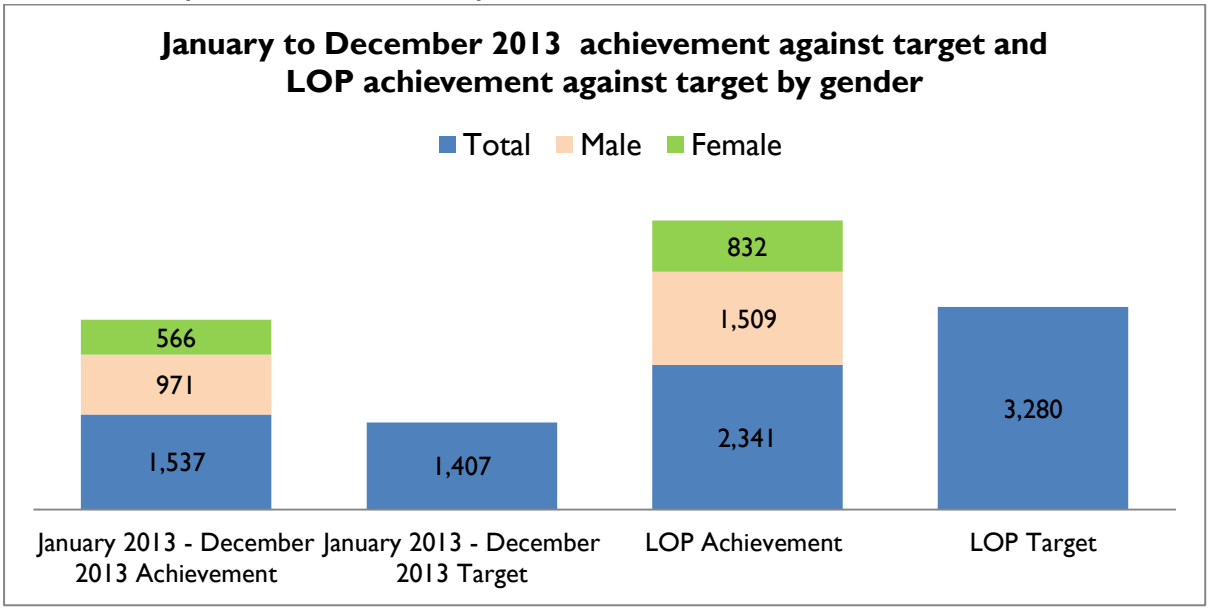
Behavior Change Communication (BCC) Framework: The BCC framework was developed to guide development, implementation and assessment of community BCC campaigns, materials and capacity-building efforts of the MOH and other partners implementing BCC activities at the community level. The framework was developed in 2012 in collaboration with MOH, but the health promotion functions have since shifted to the MCDMCH, which now holds responsibility to guide coordination, planning and implementation of BCC interventions. The framework is intended to reinforce and coordinate efforts across and within national programs and to decentralize BCC planning to district and community levels. In 2013, JHU·CCP operationalized the framework by utilizing the documents in the planning process and the operationalization of the district-level BCC committees. In collaboration with MOH and MCDMCH, integration of BCC activities into annual district plans was done.

Following the development of the BCC framework, ZISSP grantees received training in BCC planning and implementation in collaboration with the MOH Directorate of Policy and planning and MCDMCH Planning Unit. The training reached 42 people (29 males, 13 females), slightly exceeding the project target of 40 participants. The training provided the grantees with the knowledge and skills in community-level BCC planning and implementation to enhance their capacity in health promotion delivery. The training also

ensured that the quality and content of BCC activities were in line with standards established by the project. ZISSP also provided 31 copies of the BCC framework to be used as reference materials by the grantees. To follow the training, ZISSP will facilitate the process to link the grantees to the district BCC coordinating committees in 2014.

During the period January to December 2013, ZISSP trained 1,537 people (971 males, 566 females) in the use of the BCC framework against a target of 1,407 (**Table 10**). A total of 2,341 individuals (1,509 males, 832 males) against a life of project target of 3,280 have been trained to apply the BCC framework in drama and theater, radio distance learning (RDL), and BCC and IEC activities.

Table 10: Number of people trained with ZISSP support to use the BCC framework (2013 and LOP data)



BCC Training of Trainers: In 2013, ZISSP supported a training of trainers for 18 provincial and district health promotion staff and CHCs (11 males, 7 females) from Southern (Kalomo), Northwestern (Mwinilunga), Eastern (Mambwe and Nyimba), Luapula (Mansa) and Copper Belt (Luanshya) provinces. The purpose of the training was to build the capacity of the health promotion staff in how to plan and implement BCC using the available tools and guidelines such as the BCC framework, drama and RDL that were developed by MOH in collaboration with various BCC stakeholders.

Radio Distance Learning: The RDL program was launched at the national level in 2013. Scripting in six languages (English, Nyanja, Bemba, Tonga, Lozi and Lunda) and the production of all 26 programs in six languages (English, Nyanja, Bemba, Tonga, Kaonde and Luvale) were completed. Due to inadequate funds, programs for Lozi, Kaonde and Luvale were not produced in 2013. A compilation of radio scripts for the community-based RDL program was completed and printed. ZISSP supported the development and distribution of support materials such as posters, discussion guides, listeners guide, registers and flip charts. The program aired on national radio and on five selected community radio stations in five provinces and six districts (Mansa, Mambwe, Nyimba, Kalomo, Mwinilunga and Fisenge). ZISSP supported the formation of 29 SMAG RDL groups, which were monitored to learn how they were progressing. The SMAG RDL groups use community outreach to engage

mothers and discuss safe motherhood issues in their communities. SMAG RDL groups, such as the Chipembe RDL group in Nyimba District, have been invited by traditional leaders to use traditional fora to discuss traditional practices that inhibit uptake of safe motherhood services available in the community.

To systematically monitor the implementation of the RDL in the BCC districts, ZISSP has developed process monitoring tools and created a SPSS database for data management and analysis. Process monitoring tools include monitoring forms for 1) the radio discussion group facilitators, 2) the media organization monitoring the radio stations; and 3) radio listening group participants. This process data, which is collected by the health center and submitted to district and provincial health offices (and to ZISSP), will later feed into the end-line survey.

Drama Capacity-Building: In 2013 ZISSP trained community theater groups in the remaining 18 health facilities in the six focus districts that were targeted for 2013. Development of a training video on Community Theater was completed in 2013. The video documented the strategic application and philosophy of community drama for health. The video captured the process of training community drama practitioners and documented the entire process of a community drama session. The video is meant to be a complementary tool that captures good practices of drama skills to provide a clear understanding of the community theater process to viewers.

ZISSP also trained 354 drama group members (221 males, 133 females) in the 20 IRS districts (in Northern, Muchinga and Eastern Provinces) to strengthen their BCC mobilization skills to increase IRS uptake. The need for such a training emerged from resistance to IRS by some community members, leading to poor IRS performance in their districts. In addition to the drama training, the district team worked with community radio stations to produce radio programs that reinforced the IRS messages. Trained drama groups were also utilized to mobilize communities during pre-spraying season in low IRS performing areas with high community resistance towards IRS. The results of mobilization will be discussed at review meetings in quarter one of 2014.

Faith Based and Opinion Leaders As Change Agents: To inform the development the Integrated Health Took Kit process, ZISSP conducted 22 in-depth interviews (IDIs) and 12 focus group discussions (FGDs) to gather information on engaging traditional leaders and to determine current strengths, weaknesses and opportunities to engaging traditional leaders as change agents. The IDIs and FGDs were held in six districts (Mansa, Kalomo, Lufwanyama, Nyimba, Chongwe and Solwezi). Prior to the IDIs and FGDs, information was gathered on how traditional leaders were previously engaged as change agents in Zambia using a rapid desk review of the existing national reports, case studies and documents. The Integrated Health Took Kit was not finalized in 2013 as envisioned due to challenges with the consultant (e.g., substandard work and missed deadlines). Nonetheless, a draft tool kit has been developed in-house which will be completed in the first quarter after pretesting. ZISSP completed and submitted a report on the engagement of traditional leaders in community health based on review of six CHC field trip reports conducted between January 2011 and December 2012. The report examined how traditional leaders have been used as agents of change in community health under ZISSP-supported programming and to make recommendations to guide future community health programming.

Intermittent Presumptive Treatment (IPTp) Research: In 2013, ZISSP reviewed the IPTp formative research report to identify key health issues. Based on the key issues, ZISSP developed a brief strategy on how to integrate key findings into BCC activities by SMAGs and traditional leaders and through community drama. Community radio stations will produce and air programs on IPTp.

3.1.5 Saving Mothers Giving Life (SMGL)

The *Saving Mothers, Giving Life* (SMGL) endeavor is a joint collaboration of multiple partners to end preventable maternal and newborn deaths during the critical period around labor, delivery and 24 hours postpartum, during which two-thirds of most maternal deaths occur. The goal of SMGL is to reduce maternal deaths by up to 50 per cent in four target districts: Kalomo (Southern Province), Lundazi and Nyimba (Eastern Province), and Mansa (Luapula Province).

A total of 1,657 SMAG members (778 males, 879 females) have been trained in the four districts with support from ZISSP. ZISSP conducted seven technical support visits to Nyimba and Lundazi to support the implementation of activities at district and health facility levels and through SMAGs groups and to provide technical support to improve implementation of the SMGL activities.

Nine district coordination meetings (out of the twelve planned) were conducted, with 18 partners consistently attending the meetings. ZISSP also provided technical and financial support for three quarterly provincial SMGL partner meetings to strengthen SMGL activity implementation and seek partner buy-in into SMGL activities for greater sustainable support. Recommendations generated from the district and provincial meetings included:

1. Involvement of the District Commissioners' offices at future district coordination meetings.
2. Involvement of traditional leaders in community-level SMGL activities.
3. Increased investment by partners in infrastructure (i.e. maternity annexes and mothers shelters), enabling women to arrive earlier at health facilities for delivery and prevent delays in transport of pregnant women who are already in labor.
4. Provide incentives and 'tools for work' for the SMAG volunteers (e.g., bicycles) and consider ways in which SMAGs can be self-sustaining.
5. Conduct periodic mentorship visits to support safe motherhood skills-building in SMAG volunteers and health staff.

ZISSP also supported two provincial and one district Maternal Death Review meetings.

The work of SMGL has resulted in several accomplishments, based on field observations and health facility data, which include the following:

- Construction of eleven mothers' shelters in Mansa with support from multiple partners.
- Increased early ante-natal clinic (ANC) attendance.

- Increased institutional deliveries due to intensified community meetings[11], general sensitization activities and one-to-one sensitization conducted by SMAGs.
- Increased male involvement in maternal and child health activities.
- Reported early identification of health problems for pregnant woman and children by the pregnant women and their household members, prompting them to seek medical attention early in communities where SMAGS are active.
- Strengthened Maternal Death Surveillance and Response Committees (MDSR) at Provincial, District and Community level provide fora to routinely identify, notify, and determine causes and possible prevention of future maternal deaths.
- Improved referral system between the community and health facilities.
- Improved safe motherhood reporting and documentation at community, health facility and district levels.

Photo 15: At right is a happy mother who delivered at a clinic in Nyimba. A SMAG member in Nyimba commented, "Early antenatal booking is now becoming common, unlike in the past when the majority of mothers booked late or not at all."

[11] SMAG members hold a series of meetings, with up to 20 people per meeting, focusing on birth preparedness, complication readiness, and access to skilled health care workers at the health facility.

IV. Crosscutting Program and Management Support

Monitoring and evaluation (M&E), knowledge management, capacity building and gender are essential cross-cutting areas. This section of the report includes key achievements of the cross-cutting issues as outlined below.

4.1 MONITORING AND EVALUATION

M&E is a fundamental tool for good program implementation and measuring progress at all levels. M&E provides feedback on program results which guide and inform program decision-making for efficient and effective program implementation. A functional M&E system leads to improved program management by and accountability of program managers. The ZISSP monitoring system focuses on the implementation of program activities and is designed to give program staff the opportunity to review their achievements against set targets and make program adjustments as necessary.

Upgrading the Database: In 2013, ZISSP successfully developed and installed the upgraded M&E database system, which aims to improve data integrity, security, and data management and reporting. Data migration from the old Excel-based database to the new ACCESS database was completed in December 2013. However, the two databases are currently running parallel until the new system is fully functional. The new system has already reduced data entry errors and time spent in cleaning the data.

Data Mapping: Since project inception, ZISSP has accumulated a rich depository of training and mentorship information, which needs to be mapped to show the geographic coverage of the different activities. ZISSP sought the services of a consultant who mapped the different training and mentorship activities. The new ZISSP M&E database has been designed in such a way that it is able to generate maps based on different variables (e.g., province, district, and gender) for trainings and mentorship activities implemented by ZISSP since the start of the project. The plan is for the mapped data to be extended to facility level. In order to facilitate this process, the program procured ARC GIS software to be used to link mapped data to the ACCESS database so that the maps can be updated internally on a quarterly basis by a GIS specialist.

Program Monitoring and Evaluation: In 2013, ZISSP revised the training register to mirror the database and provide unique identifier variables. This revision further enhanced data accuracy and reduced the chances of creating errors in double counting. During the year, the M&E team also implemented a system of tracking training registers on a monthly basis, working closely with the Finance Department. On a monthly basis, the Finance Department provides the M&E team with cash flow requests and related documents. This process enables the M&E team to be aware of planned trainings and to expect specific training registers. When expected training forms are not submitted, the M&E team is able to follow up with specific program staff. The M&E team made it mandatory that all submitted training registers must be accompanied with the daily attendance register (which comes from the Finance and Administration Department) to track the number of people who completed the training for further verification purposes. In addition, the M&E team implemented the Certificate of Completion system, where program staff is given a certificate by the M&E team when they submit the training registers or mentorship forms. This system was introduced to strengthen the process of tracking program data and has

resulted in improved data efficiency and effectiveness and improved verification of the submitted registers.

Technical Support and Research Activities: The M&E team reviewed terms of reference (TOR) documents for assessments and reports undertaken by external consultants including the LAFP assessment, peer educator training assessment, ZMLA review report, evaluation of model sites, and assessment of the provincial Quarterly Performance meetings. The M&E Unit also supported the team leaders in the finalization of the Direct Entry Midwifery Assessment report, the Child Health Corner report, the ZHWRS Evaluation report, and the assessment of the Baby-Friendly Health Facility Initiative.

The M&E team has provided technical support in establishing data management systems with ZISSP sub-grantees. During the course of the year, on-site technical support field visits were conducted to ten sub-grantees around the country. The M&E unit also provided technical support during and after the grants close-out meeting.

The M&E team worked with Abt Headquarters to prepare *The Role of SMAGs in Improving IPTp Uptake in Zambia,* a presentation made in November 2013 in Washington D.C. at the American Society of Tropical Medicine and Hygiene meeting. The M&E team worked with MOH to review HMIS data used in the study analysis.

The team continued to strengthen the working relationship with the MOH through participating and providing technical assistance during the TWG meetings, preparation of the 2013 Zambia Demographic Health Survey (ZDHS) and the Joint Annual Review.

Finally, the M&E team reviewed the 2014 budgets and successfully coordinated and finalized the program budget for 2014, which was submitted to Abt Headquarter for final review.

Reporting: The M&E team developed a data management flow chart for the ZISSP's quantitative and qualitative indicators to improve the data collection process. The flow chart shows the step-by-step process of data submission and verification and acts as a quality improvement system for the data management. This improved system has streamlined and strengthened the M&E data collection and verification process and helped in the timely generation of required data for the 2013 USAID Semi–Annual Performance Report (SAPR) and Annual Performance Report (APR). Both reports compared program performance against the set targets. The M&E team also supported preparation of the Portfolio Review report for USAID.

The M&E team was instrumental in the preparation of the ZISSP mid–term evaluation by compiling documentation on major program achievements and deliverables. The M&E team also reviewed and summarized the findings of the mid-term evaluation report, identifying gaps and areas of concern raised during the evaluation. The internal review process helped program staff to develop the 2014 plans that responded to specific identified gaps.

The M&E team also participated in a training organized by USAID in the first quarter of 2013 to learn about the USAID DevResult reporting system.

The Performance Monitoring Plan (PMP) with 2013 quantitative results for all indicators is found in **Annex 2.** The number of people receiving technical training support from ZISSP in 2013 can be found in **Annex 3.**

4.2 KNOWLEDGE MANAGEMENT

Technical Briefs and Success Stories: In 2013 ZISSP employed a technical writer who supported review and revision of program documents, including draft reports, guidelines, curricula packages and other ZISSP contract deliverable documents. Eight policy briefs on nutrition and agriculture were reviewed and formatted for the NFNC. The content of three ZISSP technical briefing papers was finalized for formatting, and team leaders drafted an additional eleven papers in different health areas. Technical briefing papers will be printed in 2014 as part of the ZISSP promotional materials.

ZISSP continued to compile and review success stories from program staff to showcase the effect of the program interventions on health where ZISSP has provided support. Eleven success stories were printed and distributed to partners. Ten additional success stories have been written by program staff and grantees and were submitted for finalization in December 2013. Nine more success stories are currently in draft form with the technical writer and are expected to be finalized in 2014.

In 2013, the Communications Specialist travelled to Western Province with the Management Specialist Team Leader and the Director of Planning from the MCDMCH. The Communications Specialist also visited Luapula Province to support writing of success stories in the community.

Project Communication Strategy: The project communication strategy on ZISSP deliverables was submitted to senior management for their review, with their recommendations incorporated. The deliverable production and dissemination strategy is a way of ensuring that all the contract deliverables are produced and disseminated as stated in the contract. The final strategy will be disseminated in January 2014.

4.2 CAPACITY BUILDING

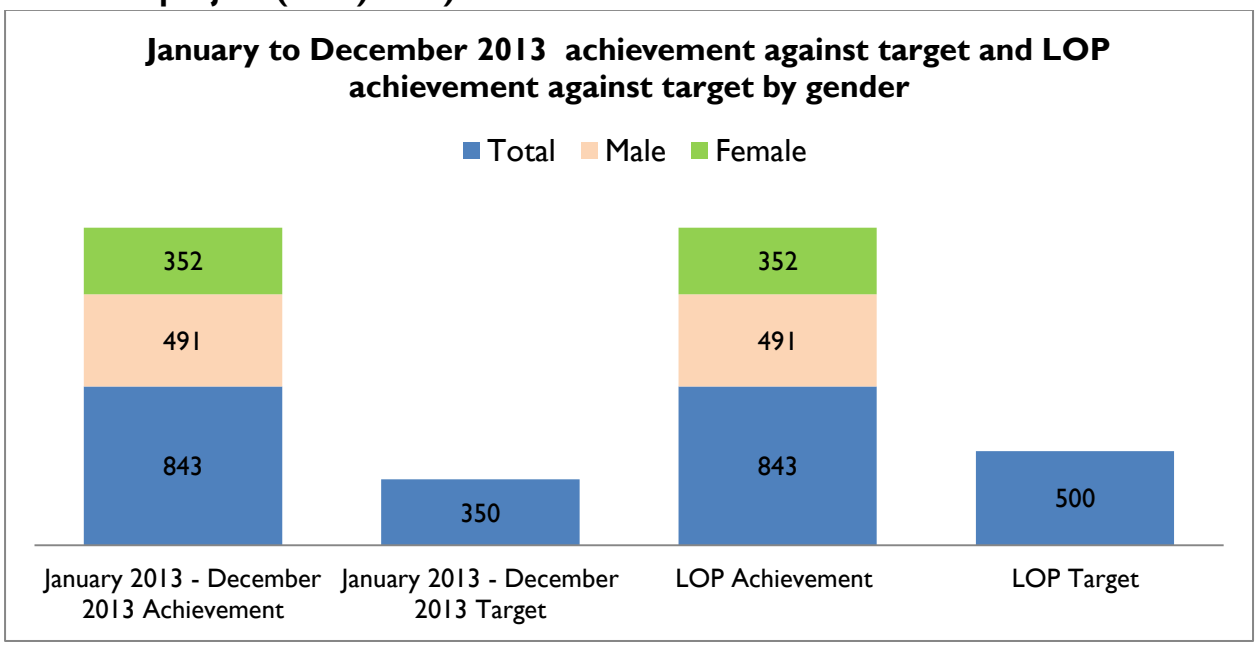
The capacity-building and gender activities have been mainly focused on leading various training and curricula review activities to ensure that, in addition to specific content, gender is mainstreamed across all focus areas.

Gender Analysis: In December 2012, ZISSP engaged a consultant to conduct a gender analysis study in Muchinga and Lusaka Provinces to establish barriers and enablers to access, and the utilization and demand for health services among women, men and youth. In 2013, the consultant completed the gender analysis report, which was presented and reviewed by the MOH and then completed based on the comments. To translate the findings of the analysis into a practical set of guidelines, ZISSP completed a summarized analysis that will be disseminated to PHOs and DHOs in the first quarter of 2014.

Gender Training: The ZISSP gender specialist oriented the entire Community Health Assistant (CHA) student body on the role that gender plays in the demand, access and utilization of health services. The orientation culminated in the formation of a school gender club with membership of the entire 292-member student body, together with their tutors. Subsequent supervisory visits to the school revealed that students had embarked on various practical approaches of sensitizing both themselves as well as communities within which they work through drama, debate and focused discussions.

The unit trained a total of 843 persons in gender in 2013 (491 males, 352 females), exceeding the life of project target of 500 (**Table 11**).

Table 11: Gender training conducted by ZISSP, by gender of participants (2013 and life of project (LOP) data)



Other Gender Support: The Capacity Building Unit participated in the MCDMCH and MOH national and provincial annual planning launches by preparing a presentation on gender and Community Health Assistants that was disseminated by CHCs in all provincial planning launches.

Capacity-Building Support: In 2013, the unit supported multiple ZISSP teams in the development and review of various curricula and guidelines, including the following:

- Harmonization of the *National Peer Educator's Training Manual for Adolescents*, which harmonized various approaches from all stakeholders involved in adolescent health in Zambia into a national training package.
- Review of *Simplified Guide to Community Health Planning* to incorporate gender. The document is at the final validation phase, i.e., with the ZISSP senior management team and MCDMCH before printing.
- Development of a working concept paper that outlined the need to integrate LAFP and ADH (incorporating gender) into the midwifery and general nursing pre-service curricula.
- Analysis of the *2012 MOH National Training Operational Plan (NTOP)* to establish the extent to which the previous NTOP (2008) met the set objectives as well as propose new areas for inclusion and implementation.

4.4 FINANCE AND ADMINISTRATION

During 2013, ZISSP's Finance and Administration Department focused its attention on strengthening internal operational systems to improve program delivery and accountability.

The Department;

- Supported the FY2013 work plan budget process to effectively contribute towards achieving ZISSP's program goal.
- Implemented the use of new accounting software, Quickbooks, to improve efficiency through allowing multiple-user data entry.
- Implemented Online ROV (Remote Overseas Voucher) reporting through the International Site Management System (ISMS) in order to improve on efficiency and availability of accounting data to the home office.
- Provided field financial support to grantees.
- Carried out a physical inventory and asset verification exercise to ensure accurate recording and reporting of project assets and inventory.
- Eased the storage problem experienced at the head office by rearranging the storage facility and sourcing additional storage space from a third party service provider.
- Supported two administration staff to a training workshop on planning and resource management.
- Trained 23 out of 26 project drivers in First Aid and CPR. Defensive driving materials were also distributed to all the drivers.
- Provided support and logistics for the IRS implementation season by establishing an efficient system for paying allowances to spray operators and their supervisors and vendors through a mobile payment mechanism.

Overall Budget and Expenditure: As of 31 December 2013, ZISSP spent a cumulative amount of US$ $63,475,513 against the current obligations of $64,254,474.00. Cumulatively, ZISSP has spent 72% of the total project estimated ceiling of $88,092,613.

Human Resources: ZISSP has a total of 104 staff including 4 senior management staff, 57 technical staff, 18 finance and administrative staff, and 25 drivers.

The project had seven employee separations in 2013: Child and Reproductive Health Team Leader, Clinical Care Specialist (North-western Province), SMGL District Coordinator (Lundazi), Human Resources Manager, Program and Executive Assistant, Driver (Central Province) and one staff member passed away, the CHC (Western Province).

In 2013 the project recruited the following staff:

1. Nutritionist
2. Monitoring and Evaluation Manager
3. Monitoring and Evaluation Officer
4. Community Health Coordinator (Mongu)
5. Geographic Information Specialist
6. Clinical Care Specialist (North Western Province)
7. Clinical Care Specialist (Luapula Province)
8. Grant Accountant
9. Human Resource Manager
10. SMGL District Coordinator (Lundazi)
11. EmONC Specialist
12. Malaria Clinical Training Coordinator
13. Human Resources for Health Officer

14. Technical Writer
15. SMGL Liaison Coordinator
16. Program & Executive Assistant
17. Driver (Northern Province)
18. Driver (Western Province).

Two positions (Malaria Team Leader and Child and Reproductive Health Team Leader) were filled through promotions of internal staff.

In 2014 ZISSP will be recruiting for the positions of Director-Technical Support, Clinical Care Specialist (Western Province), Grants Capacity Building Officers (x 2), Grants Accountant, Data Entry Assistant, and Driver (Central Province).

4.5 INFORMATION TECHNOLOGY

Information Technology (IT) Inventory: ZISSP conducted a comprehensive inventory verification exercise of all IT equipment and assets. The results have been uploaded to an application called "ABC Inventory", which will provide more comprehensive asset tracking and reporting.

Help Desk System: The Help Desk system at Abt underwent a number of transformations, including efforts to provide detailed reports on response status (open, waiting, closed), response time, and escalations. A new system to replace the current Help Desk will be piloted in 2014 in several locations including Zambia.

Service Level Agreement and Repairs: In a bid to ensure that equipment within the project is in working order, ZISSP has contracted Netcom under a service level agreement (SLA) to provide quarterly IT servicing and general machine cleanup. This SLA is intended to prolong the lifespan of the equipment and reduce the need for the organization to purchase new hardware, especially as the project winds down in 2014. In the half year since entering into the SLA, Netcom has supported general computer cleaning and overhauling the Local Area Network and networking devices. As a result, devices now have updated software and faulty cables in the building have been replaced and patch cables and fly leads supplied to replace the worn out cabling over the years.

IT Systems Upgrades: In 2013, Abt undertook some of the most extensive system upgrades to their IT infrastructure and systems to date. The IT team in Zambia was part of the roll-out team and provided support in Zambia and other regional offices. Of note were the following:

- Roll out of AGI (Abt Global Intranet). Among the notable achievements of AGI, was having more staff use the online My Prep system that has been established to compliment and ultimately replace the paper-based performance appraisal system.
- The Zambia office has also had a riverbed device installed on the network that will see the improved access to Abt resources in the US offices by the Lusaka offices. This will be possible by having a dedicated channel available via the internet. Systems to benefit from this investment will notably be iSMS, Oracle and all AGI resources.

On the local scene, QuickEdge (ZISSP's ISP) has been bought by iSAT Africa. Initially, this change was characterized by very bad internet service as they moved all their clients to a new system called MPPLS (Multiprotocol Label Switching). This system will not allow ZISSP

to link all its site offices to the Lusaka office. By providing ZISSP with its own communication channel, it will now be possible to setup IP phones in all our sites offices, improve information sharing, backups and patch management. This change has also seen the upgrading of the Lusaka internet bandwidth from 6Mbps to 10Mbps.

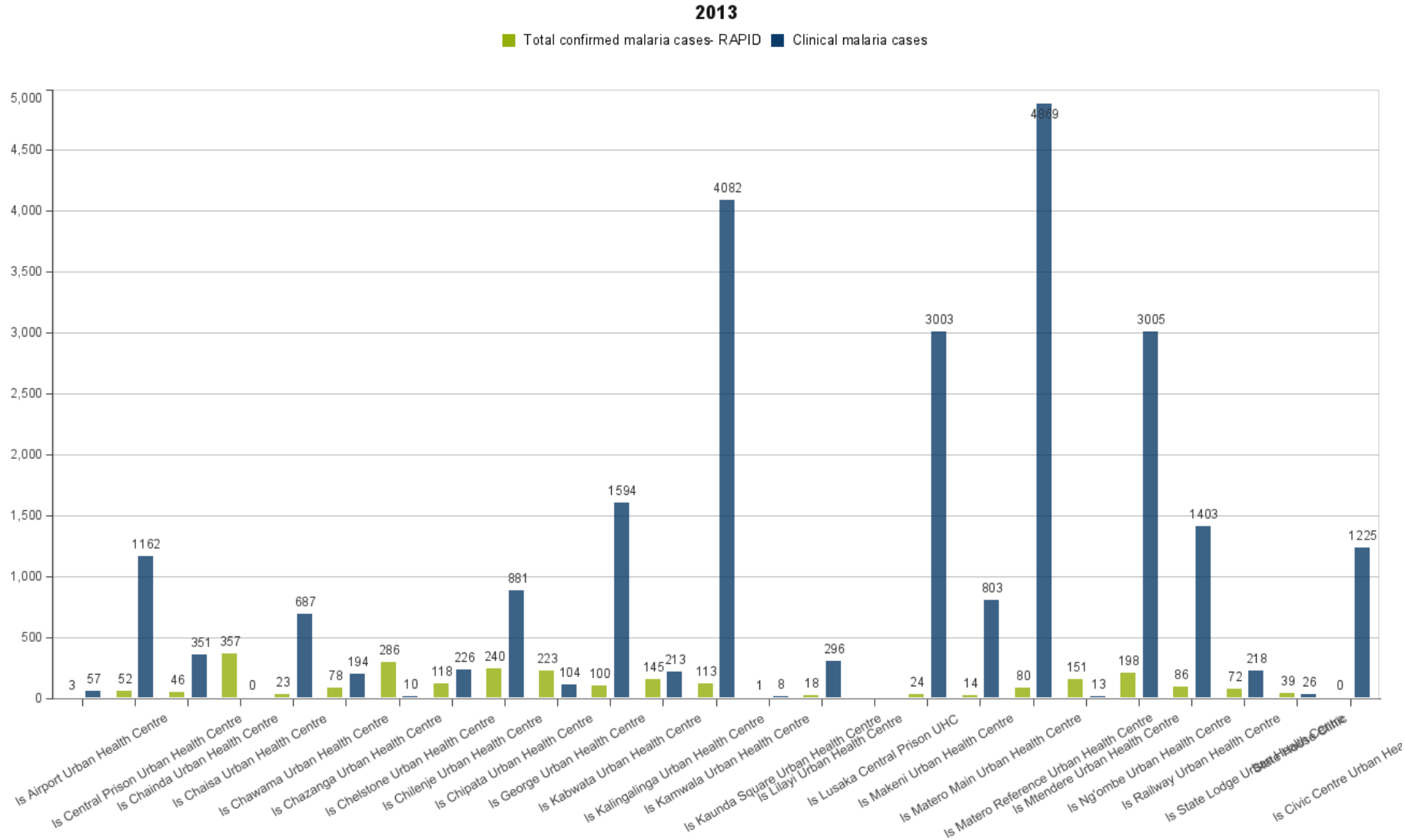
International Computer Driving License (ICDL) Training: Of the 55 staff who were eligible to study ICDL, two successfully completed the seven modules, and four attempted at least one exam. While this activity was attached to staff individual goals, there has been very little uptake on writing exams despite efforts to provide tutorials to staff.

V. CHALLENGES AND SOLUTIONS

Challenges	Proposed Solution
Frequent transfers of HR staff in management positions under the DHRA affected momentum for implementation of planned programs.	Ensure timely induction of new staff for continuity of HRH program implementation.
Changing HRH activity priorities affected implementation of planned programs.	Consultations for inclusion of programs for implementation under HRH should be extended to include Cabinet Office.
Delayed gender orientation of the PHOs and DHOs due to late completion of the gender analysis report.	Conduct orientation for PHOs and DHOs in first quarter of 2014.
High rate of attrition for the ZISSP-seconded CCS in Luapula Province contributed to coordination problems and lack of continuity of clinical mentorship and QI activities.	This position was filled in the third quarter 2013.
Delay in developing the questionnaires for the NHA 2011-12.	In 2014, ZISSP will hire an external consultant on behalf of MOH and MCDMCH to finalize production and customization of the questionnaires.
Re-alignment of MOH and MCDMCH with unclear mode of operation.	Program provided financial/technical support to both Ministries during planning and implementation of various systems work to initiate capacity building initiatives to the new Ministry, MCDMCH.
Stock outs of contraceptive commodities in some districts.	DCMOs to work with partners (ChildFund, Jhipiego, Zambia Scale-Up FP, PPAZ, Society for Family Health, Marie Stopes, etc.) in improving distribution of contraceptive commodities from districts to health facilities.

Deployment of LAFP-trained providers to other departments (paediatric, surgical etc.)	Orientation of managers on the importance of retaining skilled providers in appropriate departments.
Inadequate basic equipment to facilitate the provision of quality LAFP services.	The DCMOs to include justification for procurement of basic equipment required for the provision of LAFP methods in their annual action plans, either putting it into the government budget or budgeting the procurement under partner support.
Lack of supportive supervision of the CBDs in the provision of community-based services.	Orientation of managers at all levels has been rescheduled to February. Increased understanding of the CBD program through orientation is expected to foster ownership of the CBD programs.
No commodities for CBDs to distribute in some districts.	Inclusion of provincial, district and health facility pharmacists in the orientation of managers on the CBD program to improve movement of commodities from district to health facility levels.
Inadequate basic requirements for the CBDs to effectively provide CBD services.	The DCMOs to prioritize CBD requirements (e.g., trunks for storage of commodities, bags for carrying commodities in the field, client cards and registers and bicycles for mobility in the rural areas) and either budget for the purchase or source through partners.
Inadequate child health materials and supplies such as vaccines, Child Health Cards, salter scales, weighing bags and facility-level transport.	MCDMCH, in collaboration with partners, to facilitate timely vaccine forecasting using head count population figures and to include printing and purchase of supplies in action plans.
Inadequate number of trained staff and volunteers in IYCF and RED for sufficient impacts and coverage in service delivery.	To work with DCMO for inclusion of budget to train staff in IYCF and RED to reach recommended saturation levels.
Inadequate funding and cooking demonstration materials to support implementation of nutrition-related activities on a continuous basis in the communities.	The DCMOs to work with facility and communities to plan and budget requirements to sustain nutrition interventions.
Poor reporting of nutrition activities implemented at community level to facilitate effective monitoring of health outcomes and impact reductions on interventions implemented.	DCMO, in collaboration with stakeholders, to include nutrition data in the community reporting forms, registers and reporting tools.

Annex 1: Confirmed and clinical malaria cases, Lusaka District (all sites), 2013



Annex 2: M&E PMP

Indicator Number	Indicator Definition	LOP Target	LOP Achievement	January 2013 - December 2013 Target	January 2013 - December 2013 Achievement
2.2.1 a	Number of health care workers who successfully complete an in-service training program within the reporting period				
	Clinical Mentorship	9,200	7,434	3050	2,891
	Health Systems Strengthening (MLA)	1,642	1,806	900	556
	Health Systems Strengthening (Planning, PMP, MBB, HR, CHA Supervisors)	1,493	2,172	270	1,140
	Males		1,438		705
	Female		734		435
	Planning		162	90	162
	Males		128		128
	Female		34		34
	Marginal Budgeting for Bottlenecks		44	60	0
	Males		34		0
	Female		10		0
	Financial Management		208		22
	Male		165		15
	Female		43		7
	Human Resource Information		45	49	45
	Males		25		25
	Female		20		20
	Work Load Indicators of Staffing Needs (WISN)		0	25	0
	Males		0		0
	Female		0		0
	Record Management		31	25	31

Indicator Number	Indicator Definition	LOP Target	LOP Achievement	January 2013 - December 2013 Target	January 2013 - December 2013 Achievement
	Males		18		18
	Female		13		13
	Strengthening Human Resource for Health (Training at Harvard School)	6	4	2	0
	Males		0		0
	Female		0		0
	Community Health Coordinators Supervisor		0		0
	Males		0		0
	Female		0		0
	Gender	500	843		843
	Males		491		491
	Female		352		352
	Strategic Information	320	63	80	27
	Males		21		21
	Female		6		6
2.2.2	Number of new health care workers who graduated from a pre-service training institution within the reporting period	580	595		288
	Males		145		0
	Female		162		0
2.2.3	Number of people trained in family planning and reproductive health with USG funds	710	515	90	131
	Health Workers	260	266	40	71
	Males		75		11
	Female		191		60
	Community	450	249	82	60
	Males		127		31
	Female		122		29

Indicator Number	Indicator Definition	LOP Target	LOP Achievement	January 2013 - December 2013 Target	January 2013 - December 2013 Achievement
2.2.4	Number of people trained in maternal/newborn health through USG supported programs		3,530		1,923
	Health Workers (EmONC Providers)	340	311	60	61
	Males		129		28
	Female		182		33
	Master Trainers	234	23		0
	Males		15		0
	Female		8		0
	Health Workers (SMAG Master Trainers)	234	198	34	47
	Males		75		17
	Female		123		30
	Community health volunteers **(SMAGs)**	3,000	2,017	1220	1,815
	Males		1,362		821
	Female		1,655		994
2.2.5	Number of people trained in child health and nutrition through USG supported programs	1,124	2,402		735
	Health Workers Grand Total		1,574	250	457
	Males		806		252
	Female		768		205
	Infant and Young Child Feeding		468		162
	Males		238		91
	Female		230		71
	Reaching Every District		246		169
	Males		137		96
	Female		109		73
	Integrated of Management Child Illness		570		126
	Males		296		65
	Female		274		61

Indicator Number	Indicator Definition	LOP Target	LOP Achievement	January 2013 - December 2013 Target	January 2013 - December 2013 Achievement
			0		
	Community - Infant and Young Child Feeding	540	730	143	204
	Males		358		105
	Female		372		99
2.3.1	Number of people trained with USG funds to deliver IRS	7,201	6,363	915	926
	Supervisor		588		62
	Male		467		51
	Female		121		11
	Spray Operators		5,775		864
	Male		4,013		583
	Female		1,762		281
2.3.4	Number of health workers trained in IPTp with USG funds	1,656	827	324	394
	Males		273		127
	Female		554		267
2.3.5	Number of people trained in malaria case management with ACTs with USG funds				
	Community Health Workers	1,512	1,194	270	532
	Males		881		353
	Female		313		179
	Health Workers		24	243	0
	Males		0		0
	Female		0		0
3.2.1.a	Number of people trained in BCC/IEC methods or materials in ZISSP target districts. (ZISSP)	3,280	2,341	1407	1,537
	Male		1,509	971	971
	Female		832		566

Annex 3: Number of participants receiving technical training supported by ZISSP in 2013, by technical area, province, district and gender

Technical Area	Type of Training	Province	District	Total Number Trained	Male	Female
in-service training program	Planning	Central, Copperbelt, Eastern, Lusaka, Luapula, Muchinga, Western	Lusaka, Lundazi, Nyimba, Isoka, Kalabo, Lukulu, Mafinga, Mambwe, Mansa, Mbala, Mkushi, Mpika, Mulobezi, Nakonde, Nchelenge, Senanga	162	128	34
	Strategic Information	Central, Copperbelt, Eastern, Lusaka, Luapula, Northern, North Western, Muchinga, Western, Southern	Chikankata, Ndola, Lusaka, Kafue, Kabwe, Kasama, Solwezi, Choma, Chipata, Kabwe, Chinsali, Mansa, Mongu, Lusaka	27	21	6
	Financial Management	Copperbelt	Ndola, Luanshya, Mpongwe, Lufwanyama, Masaiti	22	15	7
	Human Resource Information	Central	Kabwe	45	25	20
	Records Management	Copperbelt, Lusaka North Western	Lusaka, Solwezi, Kasempa, Ndola	31	18	13
	TOT on Performance Management Package (PMP)	Muchinga	Chinsali	10	7	3
	Gender			843	491	352
	CHA Students			307	145	162
MNCH/ HR	EmONC Providers	Muchinga, Copperbelt, Central, Western, North Western, Southern	Mpika, Ndola, Kabwe, Shangombo, Mwinilunga, Itezhi Tezhi, Lukulu, Serenje, Solwezi, Sinazongwe	61	28	33
	Long Acting Family Planning Methods	Eastern, Luapula, Lusaka, Muchinga, Northern, Southern and Western	Chipata, Chongwe, Mansa, Mbala, Mpika, Monze, Mongu, Shangombo, Rufunsa, Luangwa, Lusaka, Kasama and Katete	71	11	60
	Community Based Distributors of family planning methods	North-Western Southern	Mwinilunga, Sinazongwe	60	31	29
	Adolescent Health/Peer Education	Northern and Muchinga	Mpika and Nakonde	84	47	37
	Health Workers IYCF	North Western	Lumwana, Solwezi	162	91	71
	Health Workers REDs	Lusaka	Chongwe	169	96	73
	Health Workers IMCI	Central, Southern	Kabwe, Kalomo	126	65	61
	Community IYCF	Eastern	Nymba, Lundazi	204	105	99

Technical Area	Type of Training	Province	District	Total Number Trained	Male	Female
Clinical Care	Clinical Mentorship	Central, Copperbelt, Eastern, Lusaka, Muchinga, Northern, North Western, Southern Western		2,891	-	-
Management and Leadership	Zambia Management and Leadership Academy			556		
Malaria	IPTp FANC	Central, Copperbelt, Eastern, Lusaka	Serenje, Kapiri Mposhi, Mkushi, Luanshya, Kitwe, Masaiti, Lufwanyama, Ndola, Rufunsa, Serenje, Kabwe, Mkushi, Chongwe	394	127	267
	Malaria Case Management (Community HW)	Eastern, Copperbelt and Lusaka,	Mambwe, Masaiti, Chongwe, Lundazi	532	353	179
	IRS Supervisors	Central	Kabwe	62	51	11
	IRS Spray Operators	Eastern, Muchinga, Northern	Chadiza, Chama, Chinsali, Chipata, Isoka, Kaputa, Kasama, Katete, Luwingu, Mambwe, Mbala, Mpika, Mporokoso, Mpulungu, Mungwi, Nakonde, Nyimba, Petauke	864	583	281
Safe Motherhood Action Group	Community	Western Southern and Eastern	Lukulu, Kalomo, Nyimba, Lundazi	1,815	821	994
	Master Trainers	Southern	Livingstone	47	17	30
BCC	SMAG RDL leaders/ listening groups	Copperbelt, Central, Luapula, Southern	Luanshya, Serenje, Mansa, Kalomo	531	281	250
	BCC IEC	Copperbelt	Luanshya, Lufwanyama, Ndola, Masaiti	709	489	220
	Drama	Copperbelt, Southern, Luapula, Eastern, North Western	Luanshya, Kalomo, Mambwe, Mansa, Mwinilunga	304	196	108
	BCC Grants	Central, Copperbelt, Lusaka, Luapula, Eastern, North Western, Muchinga, Southern, Western	Kabwe, Lusaka, Lukulu, Kalomo, Luanshya, Mpika, Luangwa, Lundazi, Serenje and Mansa	45	30	15